1997

Sharon and Gene Atkinson v. Gem Insurance Company, Premier Medical Network, Sara Meadowcroft : Brief of Appellee

Utah Court of Appeals

John Farrell Fay; Attorney for Appellants.
Kevin J. Fife; Keffreu R. Oritt; Cohne, Rappaport & Segal; Attorneys for Appellees.

IN THE UTAH COURT OF APPEALS

SHARON AND GENE ATKINSON, Plaintiffs/Appellants, v. GEM INSURANCE COMPANY, and PREMIER MEDICAL NETWORK, and SARA MEADOWCROFT, and Does 1 to 20, inclusive, Defendants/Appellees.	: : : : : : : : : : :	Case No. 97-0491-CA

APPELLEES' BRIEF

APPEAL FROM THE THIRD JUDICIAL DISTRICT COURT
SALT LAKE COUNTY, STATE OF UTAH
HONORABLE HOMER F. WILKINSON, DISTRICT JUDGE

John Farrell Fay, Esq.
1662 Bonanza Drive
P.O. Box 68-1454
Park City, Utah 84068-1454

Attorney for Plaintiffs/Appellants

Kevin J. Fife (Bar No. 5692)
Jeffrey R. Oritt (Bar No. 2478)
COHNE, RAPPAPORT & SEGAL P.C.
525 East First South, Fifth Floor
P.O. Box 11008
Salt Lake City, Utah 84147-0008
Attorneys for Defendants/Appellees

Argument priority classification 15

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STATEMENT OF JURISDICTION

This appeal arises from a civil action brought by Plaintiffs for the recovery of damages for the denial of certain benefits under a policy of health insurance issued to Plaintiffs by Defendant Gem Insurance Company.

Jurisdiction of the Third Judicial District Court, Salt Lake County, Utah, from which this appeal arises, is based on Utah Code Ann. § 78-3-4(1) (1953, as amended).

Jurisdiction to hear this appeal is conferred upon the Utah Supreme Court pursuant to Article VIII, Section 5 of the Constitution of the State of Utah, Utah Code Ann. § 78-2-2(3)(j) (1953, as amended), and Rule 3(a) of the Utah Rules of Appellate Procedure. This case was poured over to the Court of Appeals by the Supreme Court on August 7, 1997, pursuant to Utah Code Ann. § 78-2-2(4) (1953, as amended).

Summary judgment, dismissing Plaintiffs' Complaint in its entirety and from which Plaintiffs appeal, was entered by the trial court on May 12, 1997. Appellants' Notice of Appeal was filed with the Third Judicial District Court, Salt Lake County, on June 10, 1997.

RESTATEMENT OF THE ISSUES ON APPEAL AND STANDARD FOR REVIEW

RESTATEMENT OF ISSUES

1. Did the trial court correctly rule that as a matter of law the health insurance policy was clear and unambiguous and excluded hospital expenses related to Mrs. Atkinson's oral surgery from coverage?

2. In granting Defendants' Motion for Summary Judgment on all claims, did the trial court correctly rule that there were no properly contested, genuine issues of material fact?

STANDARD FOR REVIEW

The trial court granted Defendants' Motion for Summary Judgment on all issues. Because entitlement to summary judgment, or not, is a question of law, the Utah Court of Appeals accords no deference to the trial court's resolution of the legal issue presented. Higgins v. Salt Lake County, 855 P.2d 231, 235 (Utah 1993). This Court determines "only whether the trial court erred in applying the governing law and whether the trial court correctly held that there were no disputed issues of material fact." State v. Ferree, 784 P.2d 149, 151 (Utah 1989).[1] With regard to the issues involving interpretation of the policy, this Court reviews the trial court's decision under a correctness standard, giving the trial court's interpretation no particular weight. Simmons v. Farmers Ins. Group, 877 P.2d 1255, 1257 (Utah App. 1994).

STATEMENT OF THE CASE

NATURE OF THE CASE AND COURSE OF PROCEEDINGS

The Atkinsons were insured under a policy of health and dental insurance (the "Policy") issued to them by Gem Insurance Company ("Gem"). Premier Medical Network ("Premier") is a network of approved physicians, hospitals and clinics which form a preferred provider organization network. At the time the claims that have given rise to this lawsuit were incurred, Gem's insureds were given medical care at a discounted cost to both the insureds and Gem through Premier. In

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[1] Plaintiffs cite the Court to a litany of older cases which seem to suggest that summary judgment is not appropriate unless there is no possibility that Plaintiffs could prevail at trial. See Plaintiffs' Brief, pages 2 and 3. The correct standard is that summary judgment "should only be granted when it appears 'there is no reasonable probability that the party moved against could prevail.'" Salt Lake City Corp. v. James Constructors, 761 P.2d 42, 45 (Utah App. 1988) (emphasis added, citation omitted).

addition, the Policy requires that the insured contact Premier prior to admission in order to establish medical necessity and an appropriate length of stay.

Sharon Atkinson required dental surgery, and due to a heart condition, her doctors required that this surgery be performed in a hospital. Plaintiffs contacted Premier seeking "pre-authorization" for this surgery. Premier pre-authorized the surgery but refused to pre-authorize the hospital charges connected with this surgery based upon an exclusion in the Policy which specifically excluded from coverage "hospital charges or surgical facility charges in connection with dentistry." Gem paid for the surgery but refused to pay for hospital charges, of approximately $2,000, relying upon the exclusion. Therefore, this is a case involving insureds who have received in excess of $50,000 in benefits over the life of a Policy attempting to avoid an exclusion in coverage contained in their Policy of health and dental insurance.

As with their Brief, Plaintiffs' Complaint was a morass of legal jargon and theories. Plaintiffs complained that two entities caused them damage in the amount of approximately $3,000. However, it was not clear which legal theories applied to which Defendants[2] nor, due to the headings given to each cause of action, was it clear as to what exact theories were being pursued against any Defendant. As near as could be determined by a careful reading of the Complaint, Plaintiffs alleged that Gem breached the contract, breached the covenant of good faith and fair dealing, breached fiduciary duties allegedly owed to the Plaintiffs, breached certain warranties, engaged in misrepresentations, acted in bad faith, and caused Plaintiffs emotional distress.

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[2] Defendant Sara Meadowcroft was previously dismissed from the lawsuit. **Record 27-30.**

With regard to the claims against Premier, the Complaint was even more confusing. Again, as best as could be determined, Plaintiffs alleged causes of action against Premier for breach of contract, breach of the covenant of good faith and fair dealing, bad faith, misrepresentation, breach of fiduciary duty and emotional distress.[3]

After Plaintiffs had conducted significant written discovery, including approximately 100 Interrogatories and Requests for Production of Documents to each Defendant, resulting in the production of approximately 1,560 pages of documents, Defendants moved for summary judgment on all issues raised in the Complaint. Plaintiffs responded to Defendants' motion in substance and by seeking leave to conduct additional discovery. Defendants opposed Plaintiffs' request for additional discovery in light of the issues and in light of the amount of written discovery which had taken place. On February 14, 1997, the trial court heard oral argument concerning Defendants' Motion for Summary Judgment. At that time, the trial court determined that it wanted additional briefing on the issues involving interpretation of the Policy. The trial court therefore allowed Plaintiffs to file an additional memorandum regarding this issue and Defendants the opportunity to respond to Plaintiffs' additional memorandum. In the interim, the court prohibited any additional discovery.

Defendants moved for summary judgment against Plaintiffs on all causes of action raised in the Complaint. The trial court granted Defendants' Motion on all issues. From Plaintiffs' Brief, with the exception that Plaintiffs claim that there remains one disputed fact, it appears that Plaintiffs are appealing only that portion of the grant of summary judgment dealing with their contract claims against Gem solely. Therefore, the trial court's ruling on Plaintiffs' other claims against Gem and all claims against Premier must stand. American Towers Owner's Ass'n v. CCI Mech., Inc., 930 P.2d 1182, 1185 n. 5 (Utah 1996) ("Issues not briefed by an appellant are deemed waived and abandoned"); *See also* Selvage v. J.J. Johnson & Associates, 910 P.2d 1252, 1260 (Utah App. 1996) (Issues raised for the first time in a reply brief will not be considered on appeal).

Both parties filed their additional memoranda. On April 18, 1997, the trial again heard oral argument on Defendants' Motion.

DISPOSITION OF THE TRIAL COURT

The trial court granted Defendants' Motion for Summary Judgment on all issues raised in Plaintiffs' Complaint.

STATEMENT OF RELEVANT FACTS

1. On or about June 20, 1994, Plaintiffs purchased a Policy of health insurance from Gem, policy no. UTI17867-2. **Record ("R.") 3, 4 & 35.**

2. In addition to the health insurance purchased under the Policy, Plaintiffs purchased a dental coverage rider to receive dental benefits. **Id. A True and correct copy of the Policy is attached hereto as Appendix "A."**

3. In May, 1995, Plaintiff Sharon Atkinson began suffering from a heart problem. At or about this same time, she suffered abscessed teeth. **R. 4.**

4. In December, 1995, Sharon Atkinson's physicians and oral surgeons determined that tooth extraction needed to be done, and that because of her heart condition, the surgery should be done only in a hospital. **Id.**

5. Plaintiffs made requests for pre-approval by Gem and Premier of the surgery and insurance benefits covering the tooth extraction surgery. **R. 4 & 5.**

6. Based upon Policy exclusions, Premier refused to certify Plaintiffs' request for pre-certification of the hospital charges incurred in connection with the surgery in accordance with the terms of the Policy and Gem denied these benefits. **R. 4, 5, 35, 36.**

7. Gem is a first-party insurer and Premier is not an insurer at all. Also Plaintiffs do not have a direct contractual relationship with Premier. **R. 165.**

8. On or about February 5, 1996, Plaintiff Sharon Atkinson had abscessed teeth removed. **R. 7 & 36.**

9. Taking the Policy as written, it contains a Table of Contents which lists Major Medical Expense Benefits and Dental Expense Benefits separately. **R. 239 & 261.** ***See also*** **Appendix A.**

10. The major medical expense benefit portion of the Policy begins on page 1 under the heading "**GEM INSURANCE COMPANY UTAH INDIVIDUAL MAJOR MEDICAL INSURANCE PLAN.**" **R. 240 & 261.** ***See also*** **Appendix A, page 1.**

11. The medical portion of the Policy contains the following benefits:

a) Hospital room and board including all customary daily services and nursing charges . . .

b) All other necessary hospital services for medical care and treatment rendered on an inpatient or outpatient basis.

c) Medical care and treatment including surgery provided by a Physician/Practitioner and assistant surgeon . . .

R. 249 & 261. ***See also*** **Appendix A, page 19, paragraphs 1, 3 & 5.**

12. However, the health portion of Policy contains an exclusion which excludes:

> Dental x-ray and any dental services, including orthodontic services and oral surgery performed on or to the teeth, nerves within the teeth, gingivae, or alveolar process. This exclusion will not apply if . . . dental coverage is selected and the premiums are paid by You.

R. 77 & 245. ***See also*** **Appendix A, page 12, General Exclusion 22.** (Emphasis added.)

13. The dental portion of the Policy, which is only available if premium is paid for dental coverage, provides the only coverage for dental services and begins at page 27 under the heading "**GEM INSURANCE COMPANY INDIVIDUAL DENTAL CARE EXPENSE BENEFIT**", after the major medical expense benefit and maternity expense benefit portions of the Policy. **R. 253 & 262.** ***See also*** **Appendix A, page 27.**

14. The dental portion provides benefits for the dental benefits identified by Plaintiffs, such as palliative emergency treatment, oral surgery and tooth extraction. **R. 253 & 262.** ***See also*** **Appendix A, pages 27 & 28.**

15. However, the dental portion of the Policy, like the medical portion of the Policy, contains exclusions and limitations. For example, it provides for palliative emergency treatment, but only when that is the sole treatment provided on that day. If other charges are incurred at the same time, such as exams, surgery, etc., then those services will be paid in lieu of palliative emergency treatment. **R. 254 & 262.** ***See also*** **Appendix A, page 29, paragraph 5. B. (1).** The dental portion of the Policy specifically excludes "[h]ospital charges or surgical facility charges in conjunction with dentistry." **R. 77 & 254.** ***See also*** **Appendix A, page 30, Exclusion D.**

16. In spite of the many provisions of the Policy cited by Plaintiffs which tend to make the impression that their claim is for all services rendered in connection with Sharon Atkinson's oral surgery, Gem paid benefits for the oral surgery, anesthesiologists, anesthesia and all other benefits related to the oral surgery in accordance with the terms and conditions of the Policy. The only benefit denied was Plaintiffs' claim for hospital charges incurred in conjunction with the practice of dentistry. **R. 62-63 & 219-222.**

17. To date, Gem has refused to pay claim benefits for hospital charges in the amount of $1,844.20 relying on the dental exclusion of the Policy. However, Gem has paid $778.00 in connection with the oral surgery and in fact has paid over $50,000 in claims for the benefit of the Atkinsons. **R. 62-63.**

SUMMARY OF ARGUMENT

The Atkinson's were insured under a policy of health and dental insurance issued to them by Gem Insurance Company. While the policy was in force, Sharon Atkinson required dental surgery, and due to a heart condition, her doctors required the surgery be performed in a hospital. Plaintiffs contacted Premier seeking pre-authorization for this surgery. Premier pre-authorized the surgery but refused to pre-authorize hospital charges connected with the surgery based upon the exclusion in the Policy which specifically excluded from coverage "hospital charges or surgical facility charges in connection with dentistry." Gem paid for the surgery but refused to pay for hospital charges relying upon the exclusion. Plaintiffs brought suit against Gem and Premier asserting, among other claims, claims for breach of contract, which are the claims on appeal. After conducting significant discovery, Defendants moved for summary judgment on Plaintiffs entire Complaint. Summary judgment was granted for Defendants by the trial court. In granting Defendants summary judgment on Plaintiffs' contract claims, the trial court ruled that the Policy clearly and unambiguously excluded from coverage Plaintiffs' claims for hospital expenses incurred in connection with the dental surgery.

The Policy unambiguously excludes coverage for Mrs. Atkinson's hospital charges incurred in connection with her dental surgery. A policy of insurance is to be construed according to the same rules as any other contract. If the policy is determined to be unambiguous, words

were taken and understood in their plain, ordinary and popular sense, as a reasonable person with ordinary understanding would construe them. Only if an ambiguity exists does doubt result against the insurer. The policy may be ambiguous if it is unclear or omits terms or because two or more provisions, when read together, give rise to inconsistent or different meanings. A policy is not ambiguous just because one party attaches some other possible meaning.

Regarding exclusions, an insurer may contract with its insurance concerning the particular risks it will undertake and the risks it will not assume, so long as the policy does not violate statutory law or public policy. Simply because a policy contains an exclusion does not create an ambiguity, as exclusions are necessarily inconsistent with coverage. Concerning exclusions, courts are to look at the activity giving rise to the exclusion, not the insureds characterization of the activity, if the exclusion applies.

Plaintiffs claim the hospital expense exclusion when compared to the entire Policy is ambiguous. Plaintiffs admit that they had health insurance coverage under the health portion of the Policy and dental coverage under the dental portion of the Policy. However, in spite of the clear exclusions in each portion of the Policy, Plaintiffs want to recover dental benefits under the medical portion of the Policy and medical benefits under the dental portion of the Policy. The medical portion of the Policy excludes:

> Dental x-rays and dental services, including orthodontic services and oral surgery performed on or to the teeth, nerves within the teeth, gingivae or alveolar process. This exclusion will not apply if . . . dental coverage is selected and the premiums are paid by You.

The dental portion of the Policy excludes from coverage "hospital charges or surgical facility charges in conjunction with dentistry."

Plaintiffs are claiming that because the medical portion of the Policy covers medically necessary treatment, which Mrs. Atkinson's hospitalization was, the hospital charges should be covered. While, the Policy generally covers medically necessary treatment, it excludes some specifically medically necessary treatment from coverage. For example, it excludes medical treatment for injuries sustained while committing a felony. In addition, it excludes hospital charges incurred in connection with dentistry. Here, Mrs. Atkinson's surgery was clearly dental surgery and the hospital charges were incurred in conjunction with that surgery.

The Court must construe the Policy in an attempt to harmonize and give effect to all Policy provisions. All dental benefits are payable only under the dental portion of the Policy. This is why the insured must elect this rider and pay premiums associated with this coverage. Without dental coverage, oral surgery, regardless of where it is performed, is excluded from coverage under the medical portion of the Policy. It is undisputed that Sharon Atkinson's surgery on February 5, 1996 was to remove abscessed teeth. This was not medical surgery and the medical portion of the Policy does not apply, under the dental portion of the Policy, the hospital charges incurred in connection with this dental surgery are excluded.

Mrs. Atkinson's underlying condition was removal of abscessed teeth, a dental procedure. While the Plaintiffs would have the Court believe that Mrs. Atkinson's underlying condition was that she was suffering from "poisoned blood," this was not the underlying medical condition for which Mrs. Atkinson was seeking treatment. Mrs. Atkinson had abscessed teeth which needed to be extracted to avoid infection. This was a dental procedure and the hospital expenses incurred in connection with this procedure are excluded.

Plaintiffs have pointed to an Outline of Coverage claiming that it does not currently exclude hospital expenses incurred in conjunction with dentistry. The outline of coverage is a summary of coverage given to insureds by Gem. The Outline of Coverage specifically states that it is not the Policy and that only the actual Policy provisions will control. In addition, Plaintiffs' claim that the outline of coverage provides 100% coverage for dental services is not correct. The outline of coverage clearly addresses only preventative and diagnostic care when referring to 100% coverage. Mrs. Atkinson's treatment was not preventative or diagnostic dental care.

Plaintiffs also claim that the phrase "in conjunction with dentistry" is internally vague and ambiguous as it does not define its terms. Policies need not define each and every term so long as that term is easily understood by a person of average intelligence. "In conjunction with dentistry" is easily understood.

In their Brief, Plaintiffs have attempted to rely upon the reasonable expectations doctrine. First, the reasonable expectations doctrine cannot be used to enforce a contract when those reasonable expectations conflict with the plain terms of the policy. Second, the Utah Supreme Court has explicitly rejected the reasonable expectations doctrine.

Plaintiffs confuse the simple issue of whether they are entitled to hospital benefits incurred in conjunction with Mrs. Atkinson's oral surgery by attempting to have the Court believe that their contractual claim is for more than hospital charges. Gem paid all of their claims associated with this surgery, including claims for the tooth extraction, oral surgeon, pain management and anesthesia. The only claim not allowed was the claim for hospital expenses. In addition, Plaintiffs' attempt to bring a claim for hospital expenses under the provision of the Policy which provides coverage for "palliative emergency treatment." Palliative treatment is treatment to

alleviate pain. The extraction of Mrs. Atkinson's abscessed teeth cured the condition, and the lessening of pain was only secondary. More importantly, the Policy covers palliative emergency treatment only when it is the sole service provided on that day. If any other service is provided on the day of the emergency treatment, such as oral surgery, then those charges are paid in lieu of the charges for palliative emergency treatment. Also, Mrs. Atkinson's treatment was not an emergency in nature as the treatment took place approximately ten months after diagnosis.

Plaintiffs' claim that a contested issue of fact remains regarding Premier's refusal to pre-certify medical expenses and, therefore, the Court erred in granting Defendants' Motion for Summary Judgment. This position is incorrect. In moving for summary judgment, Defendants clearly stated that their Motion for Summary Judgment went to all claims asserted by Plaintiffs in the litigation. Defendants delineated the undisputed, material facts they believed were necessary in order for the Court to rule on Defendants' Motion, including the reason for Premier's refusal to pre-certify Mrs. Atkinson's hospital expenses and Gem's reason for refusing those expenses. These factual issues were addressed in the Affidavits of Sara Meadowcroft who had personal knowledge of the facts. Plaintiffs failed to dispute these facts as required under Rule 56(e) of the Utah Rules of Civil Procedure. In fact, in their Brief the only citation Plaintiffs give which they allege gives rise to this disputed fact is a citation to their Complaint. Plaintiffs did not submit an affidavit of anyone with personal knowledge regarding this fact or any other document supporting this allegedly disputed fact to the trial court. Since the issue was not properly disputed at the trial court level, Plaintiffs may not now raise it on appeal. In addition, the fact allegedly in dispute is not material to any claims made by Plaintiffs. Therefore, the trial court correctly

ruled that there were no disputed genuine issues of material fact in granting Defendants' Motion for Summary Judgment.

ARGUMENT

I. In that the Policy unambiguously excludes from coverage Mrs. Atkinson's hospital charges, the trial court was correct in granting Gem's Motion for Summary Judgment[4] on this issue.

Plaintiffs' contractual argument centers on two issues. First, Plaintiffs claim that the exclusion contained within the dental portion of the Policy is ambiguous when compared to the Policy as a whole. Second, Plaintiffs claim that the exclusion contained within the dental portion of the Policy is ambiguous in and of itself. Neither position is correct. This exclusion is not ambiguous when compared with any other provision in the Policy nor is it internally ambiguous.

A policy of insurance is simply a contract between an insurer and an insured, and it is to be construed according to the same rules as any other contract. Alf v. State Farm Fire and Casualty Co., 850 P.2d 1272, 1274 (Utah 1993). "If a policy of insurance is unambiguous, the words are to be taken and understood in their plain, ordinary and popular sense, as an average or reasonable person with ordinary understanding would construe them." Draughon v. CUNA Mutual Ins. Soc'y, 771 P.2d 1105, 1108 (Utah App. 1989) (citation omitted). Only if an ambiguity exists, is doubt resolved against the insurer. *Id* If the court finds that there exists no ambiguity, then there is no presumption in favor of the insured. Alf, 850 P.2d 1274; Fire Ins. Exch. v. Alsop, 709 P.2d 389, 390 (Utah 1985). Also, policies are to be read as a whole so as to attempt to harmonize and give effect to all

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[4] It does not appear from Plaintiffs' Brief that they are appealing the trial court's ruling regarding Plaintiffs' contract claims against Premier.

contractual provisions. Nielsen v. O'Reilly, 848 P.2d 665, 666 (Utah 1992). It is a question of law whether the insurance contract is ambiguous. Village Inn Apartments v. State Farm Fire and Casualty Co., 790 P.2d 581, 582 (Utah App. 1990).

A policy may be ambiguous if it is unclear or omits terms, Faulkner v. Farnsworth, 665 P.2d 1292, 1293 (Utah 1983), or because two or more provisions, when read together, give rise to inconsistent or different meanings. U.S. Fidelity and Guar. Co. v. Sandt, 854 P.2d 519, 523 (Utah 1993). In reviewing the provisions of a policy, it may also be ambiguous if it is not "plain to a person of ordinary intelligence and understanding, viewing the matter fairly and reasonably, in accordance with the usual and natural meaning of the words and in the light of existing circumstances, including the purpose of the Policy." Nielsen, 848 P.2d 666 (citations omitted). This is an objective standard not a subjective standard as argued by Plaintiffs. In order to find an ambiguity, the Policy terms must be susceptible to two or more feasible meanings. Taylor v. American Fire & Cas., Co., 925 P.2d 1279, 1282 (Utah App. 1996). A policy is not ambiguous just because one party attaches some other possible meaning. Alf, 850 P.2d 1275.

Regarding exclusions, an insurer may contract with its insureds concerning the particular risks it will undertake and the risks it will not assume, so long as the policy does not violate statutory law or public policy. Taylor, 925 P.2d 1282. "Thus an insurer may include in a policy any number or kind of exceptions and limitation to which the insured will agree unless contrary to statute or public policy." Farmers Insurance Exchange v. Call, 712 P.2d 231, 233 (Utah 1985). Exclusions to coverage do not create an ambiguity, as they are necessarily inconsistent with coverage. Alf, 850 P.2d 1275. If this were not the case, every exclusion would create an ambiguity as they always take away previously granted coverage for certain benefits. Also, while exclusions to coverage are to be

narrowly construed, courts are to look at the activity giving rise to the exclusion, not to the insured's characterization of that activity, to determine if the exclusion applies. Alsop, 709 P.2d 390-91.

A. The Policy, when considered as a whole, clearly and unambiguously excludes coverage for all hospital and surgical facility charges incurred in connection with the practice of dentistry.

Plaintiffs claim that the hospital expense exclusion when compared to the entire Policy is ambiguous. It is important to keep in mind the structure of the Policy and which of the cited provisions are contained within the health portion of the Policy and which provisions are contained within the dental portion of the Policy. While Plaintiffs acknowledge there are two separate and distinct portions of the Policy **(Plaintiffs' Brief, page 10)**[5], they attempt to confuse the issue by intermingling these two distinct portions. As a result, in spite of the clear exclusions in each portion of the Policy, Plaintiffs want to recover dental benefits under the medical portion of the Policy and medical benefits under the dental portion of the Policy.

1. Even though Mrs. Atkinson's hospitalization may have been medically necessary, the expenses for that treatment are excluded under the Policy.

In their Brief, in an attempt to avoid the hospital expenses exclusion, Plaintiffs assert that because Sharon Atkinson's doctors believed her dental surgery was medically necessary, the hospital charges incurred in connection with this surgery are covered under the medical portion of the Policy.

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[5] Plaintiffs also state on several occasions that the entire Policy is in dispute. By this, Defendants believe that Plaintiffs mean that whether the Policy is ambiguous is in dispute, not that the Policy which Plaintiffs purchased or the literal language of that Policy is in dispute. Also, on several occasions Plaintiffs state that in moving for summary judgment Defendants made conclusionary statements not supported by facts. **See Plaintiffs' Brief, pages 11 & 12.** A simple review of Defendants' memoranda shows that this is not the case. Defendants cited the trial court to the provisions of the Policy that they believed were relevant (the facts) and stated why they believed these provisions to be unambiguous. It is up to the trial court, not Defendants or Plaintiffs, to determine whether or not that is the case. Village Inn Apartments, 790 P.2d 582.

While it is true that the medical portion Policy covers certain medically necessary treatment, Plaintiffs' position ignores the clear exclusions in the Policy. The medical portion of the Policy excludes:

> "Dental x-ray and any dental services, including orthodontic services and oral surgery performed on or to the teeth, nerves within the teeth, gingivae, or alveolar process. This exclusion will not apply if . . . dental coverage is selected and the premiums are paid by You."

***See* Appendix A, page 12, Exclusion 22**. The dental portion of the Policy excludes from coverage "hospital charges or surgical facility charges in conjunction with dentistry." **Appendix A, page 30, exclusion D.**

Gem does not dispute that Ms. Atkinson's hospital stay was medically necessary. However, this fact does not mean that the hospital expenses are a covered benefit. For example, an insurer could market a policy that excluded cancer treatment from coverage. In that case, even though everyone would agree that cancer treatment is medically necessary, there would be no coverage for that treatment. Another example of medically necessary treatment which is excluded is found within this Policy. The Policy excludes medical treatment for injuries sustained while committing a felony. **Appendix A, page 11, Exclusion 15.** If an insured were shot in the chest while robbing a bank, treatment for these injuries would be medically necessary. The treatment would nonetheless be excluded from coverage under the Policy. Plaintiffs' claim for hospital expenses incurred in connection with dentistry may be medically necessary, but like injuries sustained in the commission of a felony, is excluded under the Policy. Further, as stated in Alsop, 709 P.2d 390-91, to determine whether an exclusion applies, courts are to look to the activity giving rise to the exclusion, not a plaintiff's characterization of that activity. Here the

stated purpose of the surgery was to remove Sharon Atkinson's abscessed teeth, not to maintain her heart condition, which was secondary to the surgery. She certainly was not in the hospital on February 5, 1996, for treatment of any heart condition.

2. Medical claims are paid under the medical portion of the Policy and dental claims are paid under the dental portion of the Policy, and the Court must look to the underlying event to determine the source of the claim.

The Court must construe the Policy in an attempt to harmonize and give effect to all Policy provisions. Nielsen, 848 P.2d 666. All dental benefits are payable only under the dental portion of the Policy. This is why an insured must elect this rider and pay the premiums associated with this coverage. Without dental coverage, oral surgery, regardless of where it is performed, is excluded from coverage under the medical portion of the Policy. Thus, if Plaintiffs want to use the medical portion of the Policy to claim benefits for this procedure, then the entire procedure is excluded. It is undisputed that Sharon Atkinson's surgery on February 5, 1996 was to remove abscessed teeth. This surgery was not medical surgery and the medical portion of the Policy does not apply, and under the dental portion of the Policy, the hospital charges incurred in connection with this dental surgery are excluded.

Plaintiffs state that, any reasonable person would equate hospital charges or surgical facility charges with benefits of hospital room and board. To the contrary, any reasonable person reading the Policy would see that where dental services are being performed, benefits are payable under the dental portion of the Policy, which specifically excludes hospital charges or surgical facility charges. Any insured of average intelligence would, when receiving dental benefits, know that those benefits are paid pursuant to the dental portion of the Policy. It is simply a matter of

reading those few pages to determine what services are or are not covered. The language concerning the hospital charges is clear in that these charges are excluded from coverage under the Policy.

Under Plaintiffs' position, because they selected and paid for dental benefits, they are entitled to the hospital charges incurred under the "Covered Eligible Expenses" portion of the medical policy, paragraphs 1 and 3. However, taking the Policy as a whole, there is a specific provision limiting hospital benefits in conjunction with dental services. As with any contract, when interpreting an insurance policy, the Court is to enforce specific provisions over general provisions. Here the general provision is that hospital room and board charges and hospital services charges will be covered. The specific provision under this fact scenario is that hospital charges will not be covered when they are incurred in conjunction with dentistry.

3. Mrs. Atkinson's underlying condition was a removal of abscessed teeth, a dental procedure.

In an attempt to have the Court believe that the medical portion of the Policy should apply, Plaintiffs make the claim that the underlying reason for Mrs. Atkinson's surgery was because she was suffering from "poisoned blood." Plaintiffs claim that poisoned blood is a sickness as defined by the Policy and, as such, should be covered under the medical portion of the Policy. Poisoned blood was not the underlying medical condition for which Mrs. Atkinson was seeking treatment. Mrs. Atkinson had abscessed teeth which needed to be extracted to avoid infection. The underlying condition was not "poisoned blood", but impacted and abscessed teeth, a dental condition from which there may be the possibility of infection. Nowhere within the physicians' letters cited by Plaintiffs does the term "poisoned blood" appear. **R. 256-259.** Also, as stated

above, a policy may provide coverage for sickness in general but exclude coverage for specific illnesses or specific treatment or expenses related to that illness. Here the Policy did just that; the medical portion excludes from coverage dental treatment and the dental portion excludes from coverage hospital expenses.

Plaintiffs point to provisions of the dental portion of the Policy covering palliative emergency treatment, tooth extractions, oral surgery and periodontal services, claiming that this coverage is inconsistent with the Policy's exclusion of hospital expenses. Plaintiffs state that because anesthesia is paid only when used in connection with oral surgery, this must be inconsistent with the exclusion of hospital charges as any person would expect that oral surgery and anesthesia would only be done in a hospital setting. Anyone who has had wisdom teeth removed realizes that this is not the case. Oral surgery, including the removal of teeth, with anesthesia, is usually done in a dentist's office. Also, palliative emergency treatment, that is treatment to alleviate pain, is also usually done in a dentist's office or even more commonly through a prescription taken at home.

4. The Outline of Coverage does not provide that Mrs. Atkinson's hospital expenses will be covered.

Plaintiffs cite the Court to a provision in an Outline of Coverage, provided to Gem's insureds, which addresses the optional dental coverage. **R. 113, paragraph 5.** This provision states that to have dental benefits, an insured must select dental coverage and pay an additional premium. Plaintiffs then focus on the provision which states: "If selected this benefit includes 100% coverage of preventive and diagnostic care." Plaintiffs claim that because no exclusion of hospital charges is mentioned in this document, and because of this statement of 100% coverage,

Plaintiffs should be entitled to coverage for their hospital expenses. Plaintiffs' position is flawed in two respects. First, the 100% coverage clearly addresses only preventive and diagnostic care, which Mrs. Atkinson's treatment did not entail. More importantly, the Outline of Coverage states:

> **1. READ YOUR POLICY CAREFULLY** - This outline of coverage provides a very brief description of the important features of your policy. *This is not the insurance policy and only the actual policy provisions will control.* The policy itself sets forth in detail the rights and obligations of both you and Gem Insurance Company. It is therefore, important that you *READ YOUR POLICY CAREFULLY!*

R., 112, paragraph 1. Therefore, the cited provisions are not part of the Policy.

Gem agrees that the Court may not rewrite the Policy. Alf, 850 P.2d 1275. However, this is exactly what Plaintiffs want the Court to do. They would like the Court to rewrite the Policy to take out the hospital facility charges exclusion in order to provide Plaintiffs with contractual benefits for these services. It is clear that the claims denied were claims for "hospital charges or surgical facility charges in connection with dentistry." Plaintiffs' attempt to characterize the services as medically necessary is simply an attempt to avoid the exclusion by characterizing the claim under a theory most favorable to them. Such a theory tortures the plain language of the Policy as well as activity giving rise to Plaintiffs' claim and should not be allowed. *Id.*; Davis v. Frederick's Inc., 517 P.2d 1014, 1015 (Utah 1973). Therefore, Gem was entitled to summary judgment on Plaintiff's claim for breach of contract.

B. The hospital expense exclusion contained in the dental portion of the Policy is not internally ambiguous.

Plaintiffs claim that the phrase "in conjunction with dentistry" is internally vague and

ambiguous as the Policy does not define its terms. This is ludicrous. Policies need not define each and every term so long as that term is easily understood by a person of average intelligence. Nielsen, 848 P.2d 666 (the terms "person" and "subject to this provision" are clear to a person of ordinary intelligence). "[I]n conjunction with dentistry" is easily understood. Breaking the phrase down, and addressing only those words which are more than one syllable, it cannot be maintained that conjunction and dentistry are words that are outside the ordinary understanding of a reasonable person. Nor can it be maintained that the entire phrase is outside the ordinary understanding of a reasonable person. If hospital charges are incurred for a dental procedure of any nature, those charges are excluded.

Gem believes that the phrase "hospital charges or surgical facility charges in conjunction with dentistry" is not internally ambiguous and therefore the trial court was correct in granting Defendants' Motion for Summary Judgment on Plaintiffs' contract claims.

II. The Utah Supreme Court has explicitly rejected the reasonable expectations doctrine.

In their Brief, Plaintiffs argue that there should be coverage based upon their reasonable expectations, claiming that they expected to have coverage for all their medical and dental needs. Certainly, they did have both medical and dental coverage. However, such coverage does not provide benefits for all services; there are exclusions. Simply because Plaintiffs may have expected coverage for the hospital charges does not mean coverage is provided in spite of the exclusions. Also, Utah has expressly rejected the doctrine of reasonable expectations, holding that the reasonable expectations of an insured may not be used to enforce a contract when those expectations conflict with the plain terms of the policy. Allen v. Prudential Property & Casualty Ins. Co., 839 P.2d 798, 803 (Utah 1992); National Farmers Union v. Moore, 882 P.2d 1168,

1169 (Utah App. 1994).[6] Therefore, Plaintiffs have no claim based on the reasonable expectations doctrine.

III. Plaintiffs' only contractual claim is for hospital benefits incurred in conjunction with Sharon Atkinson's covered oral surgery and Plaintiffs' claims are not covered under any other provision in the Policy.

Plaintiffs confuse the simple issue of whether they are entitled to hospital benefits incurred in conjunction with Mrs. Atkinson's oral surgery by attempting to have the Court believe that their contractual claim is for more than the hospital charges. It is not. Gem paid all other claims associated with this surgery. Gem paid for the tooth extraction, oral surgeon, pain management and anesthesia. The only claim not allowed was the claim for hospital expenses. Therefore, many of the provisions of the Policy cited by Plaintiffs are not relevant to this claim.

Plaintiffs, recognizing that the dental exclusion is clear and unambiguous, attempt to receive coverage by citing to other provisions of the Policy and claiming that the facts support coverage under these provisions. For example, Plaintiffs claim that Sharon Atkinson's surgery was emergent in nature. However, the dental portion of the Policy does not exempt emergency surgery from the exclusion regarding hospital charges.

The only provision of the dental portion of the Policy which addresses emergency situations provides coverage for "palliative emergency treatment." **Appendix A, page 28, paragraph 4. B. (1).** This provision does not provide coverage for emergency surgery in this case, even if Mrs. Atkinson's surgery was emergent in nature. Palliative or palliate is defined as:

Plaintiffs cite the Court to Wagner v. Farmers Insurance Exchange, 786 P.2d 763 (Utah App. 1990), to support their reasonable expectations claim. This case has been expressly rejected by the Utah Supreme Court. Allen, 839 P.2d 806; Nielsen, 848 P.2d 667.

"1. to lessen the pain or severity of without really curing; alleviate; ease . . . ." *Webster's New World Dictionary, Second College Edition.* Assumedly, the extraction of Mrs. Atkinson's abscessed teeth cured the condition, and the lessening of pain was only secondary. The extraction was not strictly done to alleviate pain, such as treatment through the use of legal narcotics to alleviate a toothache. More importantly, the Policy covers palliative emergency treatment only when it is the sole service provided on that day. If any other service is provided on the day of the emergency treatment, such as oral surgery, then those charges are paid in lieu of the charges for palliative emergency treatment. **Appendix A, page 29, paragraph 5. B. (1).** Also, this claim seems to fly in the face of the facts. Sharon Atkinson was diagnosed with abscessed teeth in May 1995. **R. 4, paragraph 10.** The oral surgery did not take place until February 5, 1996. **R. 7, paragraph 13.** Such a delay hardly signifies an emergency.

Finally, Plaintiffs claim that Sharon Atkinson is suing for other contractual benefits incurred related to oral surgery to extract abscessed teeth. This is not correct. As set forth in the Affidavits of Sara Meadowcroft, Gem has paid all but the hospital charges incurred in connection with the tooth extraction surgery.

IV. Because no genuine issue of material fact was properly disputed below, Defendants were entitled to summary judgment as a matter of law.

As a final argument in their Brief, Plaintiffs assert that a contested issue of material fact should have caused the trial court to deny Defendants' Motion for Summary Judgment. This is not the case. First, Plaintiffs did not properly raise this contested issue of material fact below. Second, the fact is not material.

Rule 56(c) of the Utah Rules of Civil Procedure provides in pertinent part:

> The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.

(Emphasis added). The primary purpose of a summary judgment motion is to avoid unnecessary trials, allowing a moving party to pierce the allegations of the pleadings and determine whether there is actually a genuine issue of material fact. Dupler v. Yeates, 351 P.2d 624, 636 (Utah 1960). However, the existence of a mere question of fact will not preclude summary judgment unless the resolution of that factual issue is necessary to determine the parties' legal rights. F.M.A. Financial Corp. v. Build Inc., 404 P.2d 670, 673 (Utah 1965). In responding to a summary judgment motion, Plaintiffs cannot rely on the mere allegations in their pleadings to avoid summary judgment. Thornock v. Cooke, 604 P.2d 934, 936 (Utah 1979).

In this case, the entry of summary judgment in favor of Defendants was appropriate. As outlined below, Plaintiffs did not properly contest any material issue of fact in the trial court and, therefore, may not now do so on appeal.

A. Plaintiffs did not properly raise a factual issue regarding pre-certification of their claim for hospital expense benefits in response to Defendant's Motion for Summary Judgment.

Plaintiffs claim that a contested issue of fact remained regarding Premier's refusal to pre-certify Mrs. Atkinson's hospital expenses and, therefore, the Court erred in granting Defendants' Motion for Summary Judgment. Defendants agree that if there is a contested issue of material fact, summary judgment is not appropriate. However, Defendants dispute that this issue of fact was contested in response to Defendants' Motion for Summary Judgment.

The moving party has the initial burden of informing the trial court of the basis for its motion for summary judgment and identifying the portions of the pleadings or supporting documents which the moving party believes demonstrates an absence of a genuine issue of material fact. TS 1 Partnership v. Allred, Inc., 877 P.2d 156, 158 (Utah App. 1994). This is exactly what Defendants did. In moving for summary judgment, Defendants clearly stated that their Motion for Summary Judgment went to all claims asserted by Plaintiffs in the litigation. Defendants then delineated the undisputed, material facts they believed were necessary in order for the trial court to rule on Defendants' Motion, including the reason for Premier's refusal to pre-certify Mrs. Atkinson's hospital expenses and Gem's reason for refusing to pay those expenses. Undeniably, setting forth these facts and the claims as they related to both parties was difficult due to the style of Plaintiffs' pleadings. However, there could be no doubt that Defendants were moving for summary judgment on Plaintiffs' entire Complaint. **R. 73, 93, 178 & 271.**

Since Defendants were seeking summary judgment on Plaintiffs' entire Complaint, and fully addressed those factual issues that they believe were necessary in addressing summary judgment, it became incumbent upon Plaintiffs to come forward with evidence as allowed by Rule 56(e) of the Utah Rules of Civil Procedure to dispute the Defendants' entitlement to summary judgment. Thayne v. Beneficial Utah, Inc., 874 P.2d 120 (Utah 1994).

Rule 56(e) states:

> (e) Form of affidavits: further testimony; defense required. Supporting an opposing affidavit shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matter stated there in . . . . When a motion for summary judgment is made and supported as provided in this Rule, an adverse party may not rest upon the mere allegations or denials of his pleadings, but his response, by affidavit or as otherwise provided in this Rule, must set forth specific

> facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate shall be entered against him.

Defendants submitted the Affidavits of Sara Meadowcroft, who had personal knowledge of the reason for refusal to pre-certify and for denial of Mrs. Atkinson's hospital expenses. In their Brief, Plaintiffs state that they raised the issue of the reason for Premier's refusal to pre-certify their hospitalization in their non-verified Complaint at paragraph 12.[7] They do not state that they properly raised this factual issue at any other time in response to Defendants' Motion for Summary Judgment. In fact, Plaintiffs submitted no sworn testimony from anyone with personal knowledge regarding the reason for Premier's refusal to pre-certify the hospital expenses.[8] Also, they failed to raise the issue of disputed facts as required by Rule 4-501(2)(b) of the Utah Code

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[7] Plaintiffs cite the Court to Christensen V. Financial Services Co., 377 P.2d 1010 (Utah 1963), for the proposition that the allegations of Plaintiffs' Complaint stand in opposition to the Meadowcroft Affidavits and other materials submitted by Defendants. While Christensen has not been expressly overruled, it has been effectively overruled by the 1965 amendment to Rule 56(e) of the Utah Rules of Civil Procedure. *See* United American Life Ins. Co. V. Willey, 444 P.2d 755, 759 (Utah 1968).

[8] The only affidavit submitted in this matter by Plaintiffs was an affidavit by Plaintiffs' counsel, Mr. Fay. By way of argument, Mr. Fay's Affidavit did, in passing, address the issue of the reason for Gem or Premier's refusal to pre-certify Mrs. Atkinson's hospitalization. **R. 191.** However, Mr. Fay was not competent to testify to that issue as he lacked personal knowledge. *See* James Constructors, 761 P.2d 45-46. Instead, Mr. Fay should have had his clients submit an affidavit, which he did not do. Defendants moved to strike Mr. Fay's affidavit because it was not based upon personal knowledge and contained argument rather than fact. The trial court did not explicitly rule on Defendant's Motion to Strike. However, it did grant summary judgment to Defendants while suspending further discovery. This in effect a de facto ruling on the Motion to Strike.

of Judicial Administration. **See R. 127-133, 136-139, 142-147 & 184-198.**[9] Since Plaintiffs did not raise this question of fact below, they may not now raise it on appeal.

To the extent Plaintiffs are claiming Defendants failed to address a cause of action, the case of Simmons, 877 P.2d 1255 is instructive. In Simmons, Plaintiff filed suit against Farmers claiming breach of contract, fraud and negligence. Thereafter, Farmers filed a motion for summary judgment "for all claims" but did not address the negligence and fraud claims in its motion. Regardless, the trial court granted Farmers' motion as against Plaintiffs on all claims. Id. at 1256. On appeal, Plaintiffs claimed that the issues regarding fraud and negligence remained to be litigated. This court held that because Farmers had clearly moved for judgment "against the Plaintiffs for all claims asserted against it in [the] action" and the motion was granted, it was the final resolution of all claims below. Id. at 1257.

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[9] Because of the nature of the documents submitted by Plaintiffs, this case is confusing procedurally. To attempt to clarify the filings in this case, on October 17, 1996 Defendants filed their Motion for Summary Judgment and accompanying memorandum. On December 26, 1996, Plaintiffs filed a document entitled Memorandum in Opposition to Defendants' Motion for Summary Judgment and Declaration of John Farrell Fay in Opposition to Defendants' Motion for Summary Judgment, which, for the most part, addressed why Plaintiffs believed they needed to conduct additional discovery before addressing Defendants' Motion for Summary Judgment. **R.127-139.** On January 7, 1997, Plaintiffs filed a Plaintiffs' Supplement to their Memorandum in Opposition to Defendants' Motion for Summary Judgment. **R. 142-147.** At this point, Plaintiffs disputed a substantive portion of Defendants' Motion. On January 16, 1997, Defendants filed their Reply Memorandum. **R. 161-179.** On January 20, 1997, Plaintiffs filed John Farrell Fay's Affidavit, purporting to be filed pursuant to Rule 56(f) of the Utah Rules of Civil Procedure. **R. 184-200.** On January 31, 1997, Defendants moved to strike Mr. Fay's Affidavit. **R. 210-216.** The bases of Defendants' Motion to Strike were that Mr. Fay's Affidavit contained substantive argument as to why summary judgment was not appropriate, resulting in excessive briefing without leave of court, violating Rule 4-501 of the Utah Code of Judicial Administration. Pursuant to leave of court, both parties then filed additional memoranda on the contract issue. **R. 227-271.**

In their Brief, Plaintiffs have cited the Court to Timm v. Dewsnup, 851 P.2d 1178 (Utah 1993). The issue in Timm was not whether a fact was disputed, but rather whether Defendant's counter-claim was unaffected by plaintiff's motion for summary judgment. In that case, Plaintiff moved for summary judgment on its claims and failed to address any of the claims raised by defendant's counter-claim. The Utah Supreme Court ruled that while Plaintiff may be entitled to judgment on its claims, the summary judgment did not affect whether defendant had a valid counter-claim against Plaintiff.

Gem addressed the reason for denying Ms. Atkinson's hospital charges through the Affidavits of Sara Meadowcroft, **R. 63 & 220**, and in its various memoranda. **R. 74, 75, 164 & 261-63.** Unlike the Complaint, which is not verified, these facts were based on the personal knowledge of Ms. Meadowcroft. It was therefore incumbent upon Plaintiffs to do more than simply rely upon the allegations contained in the pleadings. Hall v. Fitzgerald, 671 P.2d 224, 226 - 227 (Utah 1983); Thornock, 604 P.2d 936. Because Plaintiffs did not do so, by the filing of an appropriate counter-affidavit, the issue was not raised at the trial and cannot now be raised for the first time on appeal. Watkiss & Campbell v. Foa & Son, 808 P.2d 1061, 1066 (Utah 1991); West One Bank v. Life Ins. Co. of Virginia, 887 P.2d 880, 882, Note 1 (Utah App. 1994).[10]

B. The fact regarding pre-certification of Plaintiffs' claim for hospital expense benefits is not material to any of their claims.

Plaintiffs' allegation is that Premier refused to pre-certify the surgery because "it did not meet our criteria for medical necessity or appropriateness." **Plaintiffs' Brief, page 35.** In

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[10] Plaintiffs have attached a pre-certification letter from Premier to their Brief as Appendix A. This letter was not attached to any of Plaintiffs' various "memoranda" and, therefore, was not before the trial court.

response, Gem denied the claim based upon an exclusion in the policy which specifically excluded from coverage, "hospital charges or surgical facility charges in connection with dentistry." This dispute of fact does not appear material to any Plaintiffs' claims. A fact is material if, once proved, it "would have the effect of establishing or refuting one of the essential elements of a cause of action or defense asserted by the parties." Wilder v. Tanouye, 753 P.2d 816, 821 (Haw. App. 1991). A material fact is also one upon which the outcome of the litigation depends in whole or in part; Atherton Condo Bd. v. Blume Development, 799 P.2d 250, 257 (Wash. 1990). Plaintiffs' claims against Gem were for breach of contract, breach of the covenant of good faith and fair dealing, bad faith, breach of warranty, breach of fiduciary duty, misrepresentation and emotional distress. Plaintiffs' claims against Premier were for breach of contract, breach of the covenant of good faith and fair dealing, bad faith, misrepresentation, breach of fiduciary duty and emotional distress. Plaintiffs failed to point out in their Brief how this particular disputed fact is material to any of these claims.

It is unclear as to what claim this fact is relevant. It does not appear to be relevant to Plaintiffs' claim for breach of contract as there is no contract between Plaintiffs and Premier and the contract between Plaintiffs and Gem specifically excludes coverage for this service.

Even assuming that there is a dispute of fact on this issue, Defendants cannot imagine how it relates to Plaintiffs' claims. At its base, the disputed fact is not whether the services were approved, but the reason for denying those services. If Plaintiffs' allegation is correct, then Premier refused to pre-certify the hospital charges due to the fact that they were not medically necessary or appropriate. This conforms with Gem's position. Gem did not pay the hospital charges because they were not appropriate due to the hospital exclusion. Either way, the

Defendants were unified in their position that the hospital charges would not be paid by Gem. If Gem's position that the policy excludes coverage for the hospital charges is incorrect, then Plaintiffs are entitled to payment for these charges. In that case, Premier's refusal to pre-certify the facility charges has led to no additional cognizable injury to Plaintiffs.[11]

Plaintiffs state that they do not need to prove their legal theory regarding this allegedly disputed fact. Plaintiffs simply throw this fact out and allege it is disputed without pointing to any theory to which it would be relevant, and thus material. Defendants agree that the disputed fact need not rise to the level of proof of a legal theory, but there must be a legal theory to which the disputed fact is relevant. To hold otherwise would allow non-moving parties to assert facts which have no relevance to their claims and assert that these facts should preclude summary judgment. A non-moving party should not be able to claim that the moon is made of cheese,

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[11] Had Premier pre-authorized the hospital expenses and Gem then denied the claim, Plaintiffs may have had a claim for estoppel. However, where the Defendants were unified in their denial of coverage for this claim, Plaintiffs could not and did not rely on their statements in going forward with the treatment. More importantly, a claim of estoppel was not raised in the pleadings nor in response to Defendants' Motion for Summary Judgment. In West One Bank, 887 P.2d 880, 882, Life of Virginia attempted to assert a claim of estoppel and waiver on appeal. This court stated:

> To preserve a substantive issue for appeal, "a party must timely bring the issue to the attention of the trial court, thus providing the court an opportunity to rule on the issues and merits . . . . The mere mention of an issue in the pleadings . . . is insufficient to raise an issue at trial and thus insufficient to preserve the issue for appeal." (citation omitted) While raised in its answer as an affirmative defense, Life of Virginia's Motion for Summary Judgment is bereft of any reference to waiver and estoppel, and the record is devoid of any evidence that Life of Virginia presented these claims orally to the trial court. Thus, we refuse to consider the issues on appeal. (citations omitted)

West One Bank was on appeal from a grant of summary judgment which was affirmed by this Court.

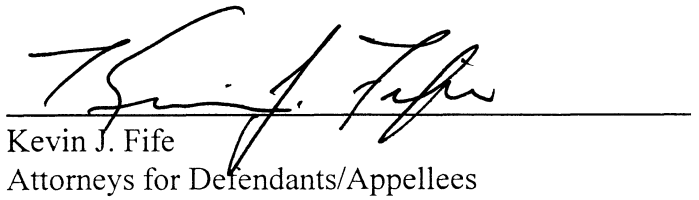
which he may truly believe, and which is disputed by the moving party, and create a question of material fact with regard to a contract or other claim.

CONCLUSION

Based upon the foregoing, Defendants respectfully request that the Court affirm the trial court's grant of their Motion for Summary Judgment.

DATED this 19th day of March, 1998.

COHNE, RAPPAPORT & SEGAL P.C.

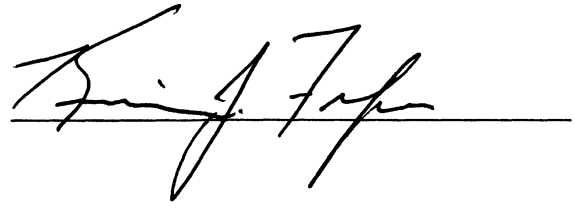


Kevin J. Fife
Attorneys for Defendants/Appellees

CERTIFICATE OF SERVICE

I hereby certify that I mailed two true and correct copies of the foregoing Appellees' Brief, postage prepaid, this 19th day of March, 1998 to the following counsel of record:

John Farrell Fay, Esq.
TESCH, THOMPSON & FAY, L.C.
Attorneys for Plaintiffs
P.O. Box 68-1454
1662 Bonanza Drive
Park City, Utah 84068-1454



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APPENDIX A

Claims and Billing Information

UTAH
521-0099

UTAH WATS
800-521-7164

NATIONAL WATS
800-888-7164

Fully Insured and Administered by:

GEM INSURANCE COMPANY®
Making Quality Health Care Affordable℠

P.O. Box 449
Salt Lake City, Utah 84110-0449

IND-UT200(E202) 940105000

GEM COST MANAGER PROGRAM
Health Care With Cost Care.

INDIVIDUAL MAJOR MEDICAL INSURANCE FOR INDIVIDUALS AND FAMILIES

GEM INSURANCE COMPANY®
Making Quality Health Care Affordable℠

UTAH

POLICY SCHEDULE

INSURED ATKINSON, GENE R
ADDRESS 150 DEMOCRAT ALLEY
KAMAS, UT 84036

INSURED DEPENDENTS
SHARON

Policy No UTI17867-2
Initial Premium
Effective Date 06-20-94
Initial Policy Term 01-20-96

INDIVIDUAL MAJOR MEDICAL
SCHEDULE OF BENEFITS

ONE MILLION DOLLAR MAXIMUM LIFETIME BENEFIT

DEDUCTIBLE AMOUNT Per person, per calendar year

Accident - All causes of accidents
Sickness - All causes of sickness
Stop Loss Amount $4000*/$5000

Co-Insurance The Company will pay the applicable percentage of eligible expenses as follows after the deductible:

60%* / 50% Elimination Disorders - Attention Deficit Hyperactivity Disorders (ADHD) - Mental/Nervous Disorders - Alcoholism - Substance Abuse
70% Extended Care Facility - Rehabilitation Therapy Services - Hospice Services, Physical Therapy

ALL OF THE ABOVE NOT APPLICABLE TO STOP LOSS AND NEVER PAID AT A HIGHER PERCENTAGE.

80% Home Health Care
80% Prescription Drugs (If $1500/$2500 deductible selected)
85%* / 70% All Other Expenses
100% Charges that are applicable to the Stop Loss once the Deductible and Stop Loss requirements have been satisfied

Deductible waived for Pre-Admission Testing and Second Surgical Opinion

CO-PAYMENTS You pay the following co-payments: †	PPO	NON-PPO
Office Visit	$10.00	30%
Outpatient Lab Test/Office Injection	5.00	30%
Outpatient X-Ray (excluding MRI & CAT Scans)	15%	30%

PHARMACEUTICAL CARD: †

Your Co-payment is:

Preferred Pharmacies	Other Pharmacies
Generic Drugs 20%	Generic Drugs 30%
Brand Drugs 30%	Brand Drugs 40%
Mental/Nervous Drugs 50%	Mental/Nervous Drugs 50%

COPAYMENTS ARE NOT APPLICABLE TO THE DEDUCTIBLE OR THE STOP LOSS.

MATERNITY BENEFIT: Included ☐ Not Included ☒

Co-Insurance The Company will pay 85%* / 70% of eligible expenses.

Maximum Benefit
Normal Delivery $2,000
Cesarean Section $3,000

Complications of pregnancy specifically defined will be covered as any other illness and will not be subject to the maximum benefits listed.

DENTAL BENEFIT: Included ☒ Not Included ☐

Deductible Amount: $50 per person, per calendar year (Waived for preventative and diagnostic care)

Co-Insurance: The Company will pay the applicable percentage of eligible expenses for dental care as follows:

100% Preventative and Diagnostic Services
50% Prosthodontic Services (Benefits available after 9 mos.)
80% All Other Services

Aggregate Maximum Benefit: $1,000 Calendar Year Per Person

* Applicable amount if using PPO Provider
† Not available on $1500/$2500 deductible plans.

Signed at the Home Office of the Company as of the date of issue

GEM INSURANCE COMPANY
SALT LAKE CITY UTAH

Secretary
President

IND-200E202
(9412010000)

GEM INSURANCE COMPANY IDENTIFICATION CARD

It's Your Choice. PREMIER

Making Quality Health Care Affordable

HEALTH INSURANCE UNDERWRITTEN BY GEM INSURANCE

NAME: GENE R ATKINSON
POLICYHOLDER: ATKINSON, GENE R
EFFECTIVE DATE: 06-20-94
POLICY: UTI17867-2
PREMIER MEDICAL NETWORK:
528 66 9841

COVERAGE
SINGLE ☐
TWO-PARTY ☐
FAMILY ☐

SEE REVERSE SIDE FOR CLAIMS AND UTILIZATION INFORMATION

Pre-certification is **required** prior to **ALL** inpatient and outpatient hospital admissions and ten (10) days prior to **ALL elective surgeries performed** outside the provider's office before any medical **costs are** incurred. For **EMERGENCY** or urgent admissions, notification **MUST** take place by the close of the next business day following admission or as soon as reasonably possible when circumstances do not allow such notice.

Please phone Premier Medical Network at **(801) 486-3383 or (800) 777-7572** Monday through Friday, 8 a.m. to 5 p.m. MST for review authorization/admission notification.

PRE-CERTIFICATION DOES NOT GUARANTEE BENEFITS OR DETERMINE BENEFIT ELIGIBILITY. FOR GENERAL BENEFIT INFORMATION, CONTACT GEM INSURANCE COMPANY AT (801) 521-0099 OR (800) 888-7164.

ANY INFORMATION PROVIDED BY PREMIER MEDICAL NETWORK OR GEM INSURANCE COMPANY SHALL NOT BE CONSTRUED TO GUARANTEE BENEFITS OR VERIFY COVERAGE. PLEASE READ YOUR PRE-EXISTING CONDITION, EXCLUSIONS AND LIMITATIONS CLAUSES IN YOUR POLICY BOOKLET.

SEND PPO CLAIMS TO:
PREMIER MEDICAL NETWORK
P.O. Box 3592
Salt Lake City, Utah 84110-3592

SEND NON-PPO CLAIMS TO:
GEM INSURANCE COMPANY
P.O. Box 449
Salt Lake City, Utah 84110-0449

For questions regarding The Premier Medical Network, please call (801) 486-3366.

TABLE OF CONTENTS

GEM INSURANCE COMPANY
UTAH INDIVIDUAL MAJOR MEDICAL INSURANCE PLAN

Insurance Provision

Thank you for choosing Gem Insurance Company as Your health insurance carrier. It is important that You read Your policy carefully As You read the policy remember the words "Company," "We," "Our," and "Us' mean Gem Insurance Company. The words "You" and "Your" mean the person named as the insured or any insured dependent named on the Policy Schedule or added at a later date by rider This policy is a legal contract between You and Us We promise to pay the benefits specified in this policy for charges incurred for Sickness or injury which occur after the Effective Date of coverage We make this promise and issue this policy in consideration of the answers given to the questions contained in the copy of the application attached to and made a part of this policy and Your pre payment of the premium listed in the Policy Schedule

Notice of Right to Review

A copy of your application is attached. Please read it. If anything shown is not correct, You must tell us The policy was issued on the basis that all material information in the application is complete and correct If not, the policy may not be valid, and We may terminate or rescind coverage If You are not satisfied with this policy after reading it, send it back to us within ten (10) days of Your receipt We will then refund any premiums You have paid, and the policy will be void and considered never in force

Renewal Agreement

This policy is renewable until you reach the age of 65 or when You are eligible for Medicare and cannot be canceled unless We cancel every policy in the same state of the same policy form The premium for this policy will be changed if like changes are made on all policies of this form issued to persons of the same age and living in the same state of residence or if due to Your age, You are placed in the next higher age bracket The change in rate will occur on the Anniversary Date following the change in age Residents in each state will be considered a separate classification

Dependent Coverage Provision

1 Dependent Eligibility
Eligible dependents are:

A. Your Spouse who is not legally separated from You,

B Your unmarried children from birth to ~~23~~ 26 years of age if they are dependent upon You for financial support according to IRS guidelines; and

C Step-children of You or Your Spouse from birth to ~~23~~ 26 years of age if they are dependent upon You for financial support and live with You in a parent/Child relationship

2 Dependent Addition

A. Newborn or Adopted Child Addition

If single coverage is carried when You have no dependents or if You carry family coverage, a newborn child will be covered automatically during the first thirty-one (31) days from birth Adopted children will be covered automatically for the first thirty-one (31) days from the date placed for the purpose of adoption. To continue coverage you must

(1) give us written notice that You want to continue coverage within thirty-one (31) days from the Child's birth or from the date the adopted Child is placed for the purpose of adoption, and

(2) pay the additional premium due within sixty (60) days from the Child's birth or date the adopted Child is placed for purposes of adoption.

If this notice is not received within thirty-one (31) days, a Medical Questionnaire must be completed by You We have the right to accept or decline coverage based upon Your answers shown on this Medical Questionnaire If We approve coverage, the Child will be added on the date We specify in writing. All time-limited benefits and the pre-existing condition limitation will apply

If single coverage is chosen when You have dependents, the thirty one (31) day coverage from the Child's birth or from the date an adopted Child is placed for the purposes of adoption is not

automatic. To initiate coverage to be effect[illegible] the premium due date after the Child's date of birth or the date an adopted Child is placed for the purposes of adoption You must:

(1) give Us written notice that You want to add coverage within thirty-one (31) days from the Child's birth or from the date the adopted Child is placed for the purpose of adoption; and

(2) pay the additional premium due within sixty (60) days from the Child's birth or date the adopted Child is placed for purposes of adoption.

If this notice is not received within thirty-one (31) days, a Medical Questionnaire must be completed by You. We have the right to accept or decline coverage based upon Your answers shown on this Medical Questionnaire. If We approve coverage, the Child will be added on the date We specify in writing. All time limited benefits and the pre-existing condition limitation will apply.

B. Other Dependents.

Additional dependents may be added as they become eligible if:

(1) You make application for coverage including the completion of a Medical Questionnaire and are approved coverage by Us based on this application; and

(2) You pay the additional premium due within thirty-one (31) days from the Effective Date if coverage is approved.

If We approve coverage, the additional dependent will be added on the date We specify in writing. All time limited benefits and the pre-existing condition limitation will apply.

3. Dependent Coverage Termination.

A. Coverage for Your Spouse will terminate on the premium due date following his or her 65th birthday or when he or she becomes eligible for Medicare.

B. Coverage for a divorced or legally separated Spouse will terminate on the premium due date following the date upon which the decree of

divorce or separation becomes final. Your Spouse may then apply for similar coverage within thirty one (31) days of termination without completing a Medical Questionnaire, unless Your Spouse has other coverage providing similar benefits which together would result in over-insurance.

C. Coverage for dependent children will terminate on the earliest of the following dates:

1) The premium due date following their ~~23rd~~ 26 birthday. The dependent may then apply for similar coverage within thirty-one (31) days of termination without completing a Medical Questionnaire, unless the dependent has other coverage providing similar benefits; or

2) The date Your Child marries; or

3) The date Your Child ceases to be an eligible dependent as defined; or

4) The date Your coverage terminates.

4. Dependent Coverage Termination Exceptions.

A dependent Child may remain on the policy beyond the specified termination date if the Child is:

A. mentally or physically incapable of self-sustaining employment; and

B. dependent upon You for support on the date specified for termination of insurance.

You must furnish proof of such incapacity of Your dependent to Us within thirty-one (31) days of the specified termination date. Coverage may be continued while such incapacity and dependency exists if the policy remains in force through the payment of premiums. We have the right to require subsequent proof of the dependent's disability and dependency at reasonable intervals during the first two (2) years following the dependent's attainment of the limiting age. After this two (2) year period, We cannot require subsequent proof more than once a year.

Termination of Coverage

Your coverage will terminate on the earliest of the following dates:

1. the premium due date following Your 65th birthday; or

2. the date You are eligible for Medicare; or

3. the premium due date following the first (30) days after You have established permanent residence in a foreign country; or

4. the date of cancellation of this policy for any reason.

If Your coverage under this policy terminates because: 1) of Your death; or 2) You have reached the limiting age, Your Spouse, if covered, will then be considered the insured. This policy may then be continued in force. If Your Spouse is not covered, then this policy will terminate for all insured family members.

Upon the termination of coverage of Your Spouse or dependent Child, Your premium will be reduced to the applicable rate if such termination changes the rate class on which Your premium is based.

Term of Coverage

The initial term of this policy begins on the Effective Date specified on the Policy Schedule. It ends on the renewal date subject to the thirty-one (31) day grace period. The policy may be renewed as specified in the renewal agreement for successive terms by advance payment to Us of the renewal premium in force on the date renewed. All such terms begin and end at 12:01 a.m. standard time at the place where You reside.

Grace Period

The first premium must be paid before We will issue the policy. After that, payment must be received within the grace period of thirty-one (31) days from the premium due date. If payment is not received within that time, the policy will be canceled. The policy will remain in force during the grace period.

Unpaid Premium

If premiums are due and unpaid at the time of payment of any claims, We may deduct the premium from the claim.

Policy Cancellation

If You desire to cancel Your policy, You must send written notice to Our home office in Salt Lake City, Utah. The date of cancellation must correspond to your premium due date, and the notice must be received prior to the designated cancellation date. Upon cancellation, your insurance will end at 12:01 a.m. on the date the next premium is due and unpaid.

Insurance With Us

You may be insured by only one (1) medical policy with Us. If You are insured with Us under more than one (1) policy, You may choose which of the policies You want to keep. We will return all premiums paid for any other policy for the period of time that You had coverage under both policies.

Policy Schedule

The Policy Schedule appears on the cover page of this policy. It is considered a part of this contract.

Definitions

Accidental Injury. Physical damage to the body which is a direct result of an accident, independent of a disease, bodily infirmity, or any other cause and which occurs while insurance coverage is in force. Physical damage resulting from a normal body movement such as stooping, bending, twisting, or chewing is not considered an accidental injury and will be subject to the Sickness deductible.

Anniversary Date. The date twelve (12) months following the original Effective Date of the policy and each twelve (12) month period thereafter.

Child. The insured's natural child, step-child, or legally adopted child.

Community Standard. The accepted standard of practice which is determined by books and journals sponsored by the professional associations and as determined by local and regional clinical leaders. Community standard is not necessarily the prevailing level of practice.

Complication of Pregnancy. Diseases or conditions which are distinct from Pregnancy but are adversely affected or caused by Pregnancy such as nephritis, nephrosis, cardiac decompensation, ectopic Pregnancy which is terminated, the spontaneous termination of Pregnancy when a viable birth is not possible, puerperal infection, eclampsia, and toxemia. Complications of pregnancy will not include false labor, occasional spotting, physician prescribed rest during the period of Pregnancy, morning Sickness, and conditions of comparable severity associated with the management of a difficult Pregnancy. Cesarean section is not considered a complication of pregnancy.

Cosmetic Surgery. Surgery performed primarily to improve physical appearance. This definition does not include surgery which is necessary:

(a) to correct damage caused by injury or Sickness while insured under this policy;

(b) for reconstructive treatment following Medically Necessary surgery while insured under this policy;

(c) to provide or restore normal bodily function; or

(d) to correct a congenital disorder that has resulted in a functional defect. This provision does not apply to coverage for a newborn or Child born under the policy or placed for the purpose of adoption under the policy.

Custodial Care. Services, supplies or accommodations for care rendered which:

(a) does not provide treatment of injury or Sickness; or

(b) could be provided by persons without professional skills or qualifications; or

(c) are provided primarily to assist the person in daily living; or

(d) are for convenience, contentment, or other non-therapeutic purposes; or

(e) maintains physical condition when there is no prospect of affecting remission or restoration of the patient to a condition in which care would not be required.

Durable Medical Equipment. Medical equipment which is all of the following:

(a) used only to benefit You in the care and treatment of a Sickness or injury; and

(b) durable and useful over an extended period of time; and

(c) used only for a medical purpose rather than convenience or contentment; and

(d) is prescribed for You by a Physician/Practitioner; and

(e) may not be used by other family members for non-therapeutic purposes.

Effective Date. The date the policy becomes effective.

Experimental Treatment. Medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which are not accepted as a valid course of treatment by Your state's medical association,

t[redacted].S. Food and Drug Administration, the American Medical Association, the Surgeon General, or any other medical society recognized by Us.

Extended Care Facility. A licensed facility operating within the scope of its license. Extended care facility services are not covered for a rest home, a home for the care of the aged, or a facility which is engaged in Custodial Care or the care and treatment of mental illness, drug or alcohol abuse or dependency.

Home Health Agency. A licensed agency operating within the scope of such license if:

(a) it is engaged in providing skilled nursing and other therapeutic services under the supervision of a Physician/Practitioner;

(b) it maintains complete clinical records on each patient;

(c) it is not engaged in providing Custodial Care, or care or treatment of mental illness, or drug or alcohol abuse or dependency; and

(d) it qualifies as a reimbursable service under Medicare.

Hospice Agency. A licensed agency operating within the scope of such license if:

(a) it is engaged in providing nursing services and other medical services under the supervision of a Physician/Practitioner;

(b) it maintains a complete clinical record on each patient;

(c) it is not engaged in providing Custodial Care, or care or treatment of mental illness, or drug or alcohol abuse or dependency; and

(d) it qualifies as a reimbursable service under Medicare.

Hospital. An institution licensed in its state and operating within the scope of such license for the care and treatment of sick or injured persons.

Inpatient. When a person has been assigned to a bed in the Hospital, other than in the outpatient department, and a charge for room and board has been made.

Insured Person. The person named as the insured of this policy or any insured dependent named in the Policy Schedule or added at a later date by rider.

Intensive Care Accommodation. A separate area of a Hospital which contains special equipment and is used only to treat the critically ill. It must provide constant nursing attendance and care by a highly skilled Physician/Practitioner. It may not be part of the Hospital used for regular confinement or normal post-operative recovery treatment or services.

Medical Questionnaire. A statement of a person's medical history upon which acceptance for insurance will be determined by Us.

Medically Necessary. Services, supplies, or accommodations received for Sickness or injury which are:

(a) consistent with the symptoms or diagnosis; and

(b) received in the most appropriate setting; and

(c) not received for the convenience of the provider, Insured Person, or any other person; and

(d) appropriate for the diagnosis or treatment of a Sickness or injury based on generally accepted medical practice in Your state; and

(e) would adversely affect the condition or quality of medical care received if omitted as determined by established medical review mechanisms.

Mental Health Professionals. Clinical and counseling psychologists, clinical social workers, psychiatric nurse practitioners, and psychiatrists who are duly licensed by the state to practice independently within the scope of their license and other training and abilities. In states where licensure does not exist, certification by a recognized professional organization may substitute for licensure.

Occupational Therapy. The use of any occupation or creative activity for remedial purposes or to restore a sick or injured person to a state of self-sufficiency or to gainful employment to their highest attainable skill.

Physician/Practitioner. A licensed medical professional performing or rendering services within the scope of that license for an expense incurred due to an injury or Sickness. Physician/practitioner services are not covered if the physician/practitioner resides in the same household as You or is a member of Your immediate family.

Pregnancy. Childbirth, miscarriage, or any complications arising from those conditions.

Rehabilitation Therapy. The treatment of disease by physical agents and methods to assist in the rehabilitation and restoration of normal physical bodily form and function after a Sickness or injury.

Short Stay Maternity. A confinement of 24 hours or less in any licensed facility where care and treatment of delivery and a newborn Child is provided.

Sickness. Illness or disease of an Insured Person which first manifests itself after the Effective Date of coverage and while the insurance is in force.

Spouse. A person married to the insured under legally valid license or certificate of marriage.

Stop Loss. The maximum amount of eligible charges for which the Insured Person has a co-payment responsibility.

Usual and Customary Charge. The usual and customary charges for services and supplies in the community where such services and supplies were provided.

Policy Specifications

You waive coverage of the following exclusions, limitations, and limited benefits by purchasing this policy.

General Exclusions

1. Charges for services, supplies, or treatment provided prior to the Effective Date or after the termination date of coverage.
2. Charges covered by any Workers' Compensation policy, employer's liability, or occupational disease policy.
3. Services, supplies, or treatment which are eligible for benefits under any motor vehicle no-fault plan when You are required by law to have no-fault insurance in effect. This exclusion applies whether or not You have such coverage in effect.
4. Injury or Sickness resulting from war or any act of war whether declared or undeclared.
5. Injury or Sickness resulting from service in the military of any country.
6. Charges for services, supplies, or treatment for which benefits are provided under Medicare or any other government program except Medicaid. This exclusion applies if You are or could be covered under any such program.
7. Injury or Sickness resulting from suicide, any attempt of suicide, or from any intentionally self-inflicted injury, whether the Insured Person is sane or insane.

8. Services, supplies, or treatment for which no charge is made or for which You are not required to pay

9. Medical services which are not incident to or necessary for the treatment of injury or Sickness or which are not Medically Necessary.

10. Charges for treatment or prevention of an injury or Sickness, including mental illness, by means of treatments, procedures, techniques, or therapy outside of generally accepted health care practice.

11. Routine physical examinations, including examinations required for employment or by the government or medical examinations or diagnostic tests not connected with the care or treatment of a Sickness or injury. Exception: We will cover mammograms done on a Physician/Practitioner's referral to the extent described below:

    (a) one base line mammogram for women aged 35-39;

    (b) biennial mammograms for women aged 40-49 or more frequently if required by a Physician/Practitioner, and

    (c) an annual mammogram for women aged 50 or older.

12. Charges in connection with genetic studies, in connection with family planning, and birth control drugs, medications, and birth control devices.

13 Experimental Treatment and related charges.

14 Charges incurred for Custodial Care or diagnostic purposes if not connected with the care and treatment of a Sickness or injury

15 Charges incurred as a result of an injury or Sickness sustained while committing a felony or engaging in an illegal occupation.

16. Services, supplies, or treatment provided for Pregnancy unless maternity coverage is selected and premiums are paid by You Exception: the Complications of Pregnancy specifically defined will be covered as any other illness

17. Obesity surgery including related procedures and any charges arising from or as a direct result of obesity surgery.

18 Reversals of sterilization procedures

19 Charges in connection with Cosmetic Surgery or reconstructive or plastic surgery, including such surgery performed for psychological reasons This exclusion will not apply if surgery is performed to correct damage caused by an injury, Sickness, or Medically Necessary surgery if these conditions occur while this coverage is in force.

20 Charges in connection with the repair of congenital defects unless the Insured Person was born or placed for purpose of adoption while this policy was in effect

21. Charges in connection with breast augmentation or reduction surgery, except for cysts, tumors, the class of disease known as cancer, and due to injury.

22. Dental x-ray and any dental services, including orthodontic services and oral surgery performed on or to the teeth, nerves within the teeth, gingivae, or alveolar processes. This exclusion will not apply if such services are incurred as a result of an Accidental Injury which occurs while coverage is in force or if dental coverage is selected and premiums are paid by You.

23 Charges in connection with jaw realignment procedures including but not limited to osteotomy, temporomandibular joint dysfunction (TMJ), upper or lower jaw augmentation, reduction procedures, orthognathic surgery, injections of joints, splints, and physical therapy. This exclusion will not apply if charges are incurred as a result of an Accidental Injury which occurs while coverage is in force

24 All vision testing, training, and related services.

25 Eyeglasses, contact lenses, and/or servicing of eyeglasses and/or contact lenses.

26. Keratotomy surgery

27 Any devices used to aid hearing including but not limited to cochlear implants, the fitting of such devices, and any routine hearing tests.

28. Medical care of weak, strained, flat, unstable or unbalanced feet, and routine foot care

29 Orthopedic or corrective shoes, orthotics, or any other supportive devices for the feet.

30. Any treatment for or diagnosis of infertility, artificial insemination, or in vitro fertilization.

31 Drugs and medicines which do not bear the legend "Caution Federal law prohibits dispensing without a

prescription" and/or which are not dispensed by a licensed pharmacist.

33. Marriage counseling.

34. Assessment and treatment of learning disabilities, or disruptive behavior disorders, or conduct disorders.

35. Occupational Therapy.

36. All shipping, handling, postage, interest, finance, telephone consultation, missed appointment, travel expense, report, and completion of claim form charges.

37. All services provided in connection with ventral hernias performed in conjunction with Cosmetic Surgery.

38. Educational service or counseling including, but not limited to: sleep studies, weight control clinics, stop smoking clinics, training for care of diabetes, cholesterol counseling, exercise programs or other types of physical fitness training.

39. Vitamins, special formulas, special diets, food supplements, or preventative drugs.

40. Direct complications of any ineligible procedures, service, supply, or treatment.

41. Care, except emergency care, rendered outside the United States.

42. Growth hormones.

43. Charges incurred for any loss sustained as a result of you being intoxicated or under the influence of any illegal drug unless administered under the advice of a Physician/Practitioner.

44. Charges in connection with implantation, repair, or replacement of penile prostheses.

Pre-existing Condition Limitation

We will not pay any benefits for a loss due to a pre-existing condition until after Your coverage has been in force for eighteen (18) consecutive months. The term pre-existing condition means:

(a) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment within an eighteen (18) month period preceding the Effective Date of coverage; and/or

(b) a condition for which medical advice or treatment

was recommended by or received from a physician within an eighteen (18) month period preceding the Effective Date of coverage.

General Limitations

The following services are not covered until after You have been enrolled for six (6) consecutive months unless pre-existing, then the pre-existing condition limitation applies whether such services are due to Sickness or injury. Exception: services provided on an emergency basis will be covered, unless the condition is pre-existing then the pre-existing conditions limitation will apply.

1. Tonsillectomies, adenoidectomies, tympanotomies, or myringotomies.

2. Reconstructive knee procedures, including but not limited to arthroscopy. Exception: If surgery is performed due to an Accidental Injury resulting in new damage where no history of treatment to the knee exists and treatment is sought within forty-eight (48) hours from the accident, this limitation will not apply.

3. Diagnosis or treatment for hernia, including but not limited to hernia repair (except ventral hernias, which are not covered).

4. Submucous resection (resection of the nasal turbinates) and any treatment for a deviated septum. Exception: If surgery is performed due to an Accidental Injury resulting in new damage which is not related to a pre-existing or chronic condition and treatment is sought within forty-eight (48) hours from the accident this limitation will not apply.

5. Hysterectomies, D&C, laparoscopies, and laparotomies.

6. Sterilization procedures, including but not limited to vasectomies and tubal ligations.

7. Treatment or removal of moles, warts, or lesions.

8. Any surgical procedure of the feet involving the exposure of bones, tendons, or ligaments, including the removal of the nail matrix (root).

Limited Benefits

1. Charges for treatment of an individual for back and spine disorders, including modalities, are limited to:

(a) $25.00 per visit; and

(b) one (1) visit per day; and

(c) no more than twenty (20) visits per calendar [redacted]

This limitation does not apply to necessary diagnostic x-ray, laboratory procedures, surgery, or initial diagnostic examination.

2. Speech therapy will be limited to treatment for restoratory or rehabilitory speech therapy for speech loss or impairment due to an illness other than a functional nervous disorder or to surgery on account of an illness. If speech loss or impairment is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

3. Charges for second surgical opinion will be limited to $100 per consultation.

4. Benefits for services provided by an anesthetist or anesthesiologist for anesthesia and the cost of its administration are limited to 50% of the amount allowed for the actual surgical procedure.

5. Acupuncture, when used for the necessary treatment of an injury or Sickness, is limited to ten (10) treatments each calendar year.

6. Benefits for expenses directly related to live, cadaveric, or artificial organ, tissue or any other type of transplant, including, but not limited to heart, heart/lung, lung (single or double), liver, kidney, pancreas, cornea, bone marrow, peripheral stem cell transplants, allogeneic and syngeneic bone marrow transplants, all autologous transplants and mechanical implants are limited to $50,000 for all such expenses during the Insured Person's lifetime.

   Notwithstanding the foregoing, no benefits are available under this policy for any bone marrow transplant in the treatment of diseases or conditions resulting from treatment of acquired immunodeficiency diseases, including but not limited to, human T cell leukemia/lymphoma (HTLV-I) or acquired immunodeficiency syndrome. Additionally, no benefits are available for any bone marrow or peripheral stem cell transplant in the treatment of breast or brain cancer, myeloma, or germ cell tumors, any intestine transplant, or any transplant of a non-human organ.

   No benefits are payable under this policy unless a written pre-authorization has been obtained from the company. Requests for pre-authorization must be received by the Company at least thirty (30) days prior to the date contemplated for the procedure. Late

[redacted]equests will be denied. Pre-authorization will b denied unless the Company determines that the tran plantation is a medically reasonable and necessary se vice in the treatment of progressive, life threatenir (except corneal transplants) disease when specific c teria for patient selection are met.

7. Treatment, services, or supplies provided in connection with the diagnosis of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), c AIDS related diagnoses or opportunistic disease including Pneumocystis carinii pneumonia or Kaposi sarcoma are limited to $25,000 during the lifetime c the Insured Person.

8. MRI and Cat (CT) Scans are limited to two (2) suc scans each calendar year.

9. Pregnancy ultrasounds are limited to one (1) per Preg nancy. This benefit is only available if maternity cove age is elected and premiums are paid by You.

10. We will pay 50% to the maximum benefit describe below for the outpatient or Inpatient treatment of:

    (a) mental disorders;

    (b) alcohol and drug abuse or dependency;

    (c) Elimination disorders (as classified by the DSM-II R and the International Classification of Diseases and

    (d) Attention deficit hyperactivity disorder (ADHD provided such condition is documented by mec ical record.

Treatment must be provided directly and personally by Mental Health Professional. The treatment must meet th Community Standard of being appropriate to the disorde and of offering a reasonable expectation for recovery o significant amelioration. Inpatient treatment must tak place in a facility licensed by the state and which meet the JCAHO standard for mental health treatment. Inpa tient treatment will be covered only if the following condi tions are met:

(a) The Insured Person's mental disorder presents ar unreasonable risk to life, e g., suicide ideation severe psychosis, detoxification from central ner vous system depressant drugs, establishing lithium levels, etc.; and

(b) The Insured Person is discharged from Inpatien treatment as soon as the life threatening menta

state has passed

The maximum benefit for such treatment will be as follows.

Outpatient: Benefits for services performed on an outpatient basis are limited to $2,000 each calendar year.

Inpatient: Benefits for services performed on an Inpatient basis will be limited to.

(a) $2,500 each calendar year for treatment of alcoholism, chemical dependency, or substance abuse, and

(b) $15,000 payable during the Insured Person's lifetime for the treatment of mental illness, functional nervous disorders, elimination disorders, attention deficit hyperactivity disorders (ADHD), psychoanalytic care, alcoholism, chemical abuse, and substance abuse

11 Home health care visits will be limited to one-hundred (100) visits per calendar year and will be covered only if all of the following requirements are met

(a) Home health care is Medically Necessary,

(b) Home health care begins within fourteen (14) days after discharge from a Hospital or Extended Care Facility,

(c) The Insured Person is totally disabled and would otherwise be confined Inpatient in the Hospital or in an Extended Care Facility

(d) The Insured Person is under the direct care of a Physician/Practitioner.

(e) The plan of treatment covering the home health care is established in writing by the attending physician prior to beginning treatment.

(f) The plan or treatment covering home health care is certified by the attending physician at least once every month and the Insured Person is examined by the attending physician once every sixty (60) days

(g) Charges are for services provided by a Physician/Practitioner

12 Benefits for all services provided by an Extended Care Facility and/or provided for Rehabilitation Therapy will be limited to coverage for a maximum of thirty (30)

ays or $20 000 whichever is less, during the Insure Person's lifetime. Services provided by an Extende Care Facility will only be provided if

(a) The daily room and board rate including all cus tomary daily and nursing services do not exceed 50% of the average semi-private rate charged by Hospital;

(b) The admission begins while insurance coverage i in force;

(c) The admission begins within seven (7) days afte discharge from 1) a Hospital confinement of a least five (5) consecutive days, or 2) a prior cov ered Extended Care Facility confinement of a least five (5) days, and

(d) Is Medically Necessary for the care or treatmen of the same Sickness or injury for which You were just confined.

13 Benefits for all services provided by a Hospice Agency will be limited to coverage for a maximum of ninety (90) days during the Insured Person's lifetime.

14 Benefits for devices or appliances inserted into the body surgically will be limited to the Usual and Cus tomary manufacturer's invoice price plus 10% or $500 00, whichever is less.

15 Benefits for injuries resulting from the use of a motor cycle, motorscooter, or any other all terrain vehicle (ATV) will be limited to $25,000 for all such expenses incurred during the Insured Person's lifetime

16. Benefits for an eligible surgical procedure performed during the same operative session as a Cosmetic Surgery, plastic, reconstructive, or obesity procedure will be reduced to 50% coverage of the total covered charges for the eligible procedure.

17 Benefits for total parenteral nutrition and peripheral parenteral nutrition will be limited to $1000 for all such expenses during the Insured Person's lifetime.

Major Medical Expense Benefit

1 Maximum Benefit. The maximum benefit is listed in the Policy Schedule and is the total amount payable in Your or Your dependent's lifetime

2 Sickness Deductible Each Insured Person must meet a separate Sickness deductible. It applies to all Sick nesses during a calendar year Additionally, each

insured person must meet the co-payment requirements as outlined in the Schedule of Benefits. Co-payments are not applicable to the sickness deductible.

3. Accident Deductible. Each Insured Person must meet a separate accident deductible. It applies to all accidents during a calendar year for which services are rendered within ninety (90) days from the date the accident occurs. Services rendered after ninety (90) days from the date the accident occurs will be subject to the Sickness deductible. Additionally, each insured person must meet the co-payment requirements as outlined in the Schedule of Benefits. Co-payments are not applicable to the accident deductible.

4. Deductible Carryover. Expenses incurred in October, November, or December of any year which satisfies any part of that year's deductible will also apply to the next year's deductible. The policy must be in force at the time such expenses were incurred.

Covered Eligible Expenses

In accordance with the Schedule of Benefits, we will pay Usual and Customary Charges for the following necessary medical care, treatment, services, and supplies:

1. Hospital room and board including all customary daily services and nursing charges. Charges will be limited to the average semi-private room rate.

2. Intensive care room and board to a maximum of 300% of average the semi-private room allowance.

3. All other necessary Hospital services for medical care and treatment rendered on an Inpatient or outpatient basis and ambulatory care facility services.

4. Medical care and treatment including surgery provided by a Physician/Practitioner and assistant surgeon charges to a maximum of 20% of the amount allowed for the actual surgical procedure.

5. Nursing services provided by a registered nurse, (R.N.) or a licensed practical nurse, (L.P.N.).

6. Medical care and treatment, services, and supplies specified below when prescribed by a Physician/Practitioner:

(a) physical therapy;

(b) x-ray treatment, x-ray exams, and radioactive therapy;

(c) Medically Necessary clinical pathology and laboratory services;

(d) non-replaceable blood, blood plasma, blood derivatives, and the administration thereof;

(e) casts, splints, trusses, braces, crutches, artificial limbs, eyes, and other prosthetic devices for loss except for penile protheses which are not covered at any time, which occurs while coverage is in effect. Coverage will be limited to the initial purchase of the customary basic units only and to the replacement of such items or devices unless the replacement is required due to the following reasons:

(i) loss, theft, or negligence;

(ii) the device or item being replaced is one which would continue to meet the Insured Person's basic medical needs.

(f) Durable Medical Equipment including wheelchairs, special Hospital beds, and other mechanical equipment necessary for treatment not to exceed the purchase price for a basic unit. Benefits will be payable on a monthly basis as long as coverage remains in force;

(g) medical and surgical supplies which are Medically Necessary and cannot be used by other family members, including colostomy bags, catheters, dressings, syringes, and hypodermic needles;

(h) oxygen and rental of oxygen equipment;

(i) drugs and medicines which bear the legend "Caution, Federal law prohibits dispensing without a prescription" and are dispensed by a licensed pharmacist. Benefits for prescription drugs will be provided through Scrip Card, Inc. (Scrip). Each Insured receives a card to be presented when purchasing a prescription from a pharmacy participating in the Scrip Card plan. When an Insured Person presents the Scrip card at a participating pharmacy, he or she will pay only the co-payment percentage as shown in the Schedule of Benefits for each drug purchased for the Insured Person eligible for Scrip benefits.

The following drugs, medications, implements, and health care devices are not covered under the Scrip Card plan and must be submitted directly to Gem Insurance Company for benefit consid-

eration

(i) Syringes and/or diabetic supplies.

(ii) Compounded medications.

(iii) AZT.

(iv) Anti-rejection drugs, including but not limited to Sandimmune and cyclosporine.

The following drugs, medication, implements, and health care devices are not covered under the Scrip Card plan or under Your regular medical plan with Gem Insurance Company.

(i) Contraceptive devices, including IUD's and diaphragms.

(ii) All vitamins and health foods.

(iii) Anorexic drugs and/or drugs used for diet or obesity

(iv) Drugs that do not require a prescription, except insulin

(v) Drugs used in the treatment of impotency, infertility, or for ovulatory inducing purposes or for ovulatory inducing purposes.

(vi) Charges covered by any Workers' Compensation policy, employer's liability or occupational disease policy

(vii) Stop-smoking drugs including but not limited to Nicorette and Nicoderm patches

(viii) Rogaine

(ix) Drugs which are for experimental or investigational use.

(j) local, professional ambulance service to a maximum of $250;

(k) air ambulance to a maximum of $500;

(l) charges made by an anesthetist or anesthesiologist (as specified in the Limited Benefits Section, number 4),

(m) eligible charges for home health care as specified in the Limited Benefits Section,

(n) eligible charges for Rehabilitation Therapy as specified in the Limited Benefits Section;

(o) eligible charges for services provided by an Extended Care Facility as specified in the Limite Benefits Section; and

(p) eligible charges for services provided by a Hospice Agency as specified in the Limited Benefi Section.

(q) the Complications of Pregnancy specificall defined in the Definition section.

Policy Provisions

Entire Contract; Changes

This policy with the application and attached papers is the entire contract between You and Us Changes will not be valid unless approved by one of Our officers This approval must be endorsed on or attached to this policy No agent can change this policy or waive any of its provisions

Time Limit on Certain Defenses

1 On or after two (2) years from the date of Your coverage under this policy, no misstatements, except fraudulent misstatements, made by You on the application can be used to void the coverage or deny a claim.

2. No claim for a loss which happens after eighteen (18) months from the date of issue of this policy will be reduced or denied because a disease of physical condition not excluded by name or specific description effective on the date of loss had existed prior to the Insured Person becoming covered hereunder

Reinstatement

If the renewal premium has not been paid within the time granted for payment We may require an application for reinstatement The policy will be reinstated or denied within forty-five (45) days from the date We receive the application. The reinstated policy will cover only loss resulting from Accidental Injuries which occur after the date of reinstatement and loss due to a Sickness which begins more than ten (10) days from such date In all other respects, the Company and You shall have the same rights as each had just before the due date of the defaulted premium subject to any other provisions We tell you about in writing. We may choose to accept future premium without requiring a new application If We do this, We do not waive our right to require a new application for reinstatement if premium is not paid in the future.

Notice of Claim

You must give Us written notice of loss within twenty (20) days after the loss begins or as soon as possible. Notice can be given to us at our home office in Salt Lake City, Utah, or to one of Our agents. Notice should include Your name and the policy number. If medical records are required for benefit determination, it is the responsibility of the Insured Person to obtain the medical records from his\her provider(s). Any expense for medical records is the responsibility of the Insured Person.

Claim Forms and Proof of Loss

When We receive your notice of loss, We may send You forms for filing proof of loss. If We do not send these forms within fifteen (15) days, You will meet the proof of loss requirements by giving us a written statement about Your loss within ninety (90) days after the loss if We request it. If it is not reasonably possible to give this timely proof, the claim will not be affected if sent as soon as possible.

Time of Payment of Claims

Benefits payable under this policy for any loss will be paid immediately upon receipt of proof of the claims as described above together with receipt of supportive medical records deemed necessary by the Company.

Medical Examination and Autopsy

We have the right to have an Insured Person examined as often as reasonably necessary while a claim is pending. Any exam will be at Our expense. In case of death, We can also require an autopsy where it is not forbidden by law.

Legal Action:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Right of Recovery

Whenever covered benefits are eligible for payment by Us and those payments together with any other payments are more than the maximum payment necessary to satisfy the actual amount of the claim, We reserve the right to deduct the excess amount from the claim or to recover the excess amount from any persons to or for whom those payments

w[illegible]made or from any insurer, service plan, or any othe organizations or persons.

Subrogation

By accepting Our payment for any benefit of this policy You assign to Us all claims which You have or may have against any third party. We assume Your right to the proceeds of any settlement or judgment that may result from such claim to the extent of Our actual payments. We also assume the right to make such a claim on Your behalf to the extent of Our actual payments.

You may not do anything which would damage Our right of subrogation. You may not discharge any claim against any person or entity without Our written permission. You must cooperate with Us in pursuing Our right of subrogation including providing Us with any documents or information in Your possession or giving testimony which may be required.

Misstatement of Age

If any age or sex has been misstated, the benefits of this policy will be those the premium would have bought at the correct age and sex. If no coverage would have been available, We will refund those premiums.

Conformity with State Law

Any provision in the policy which, on its Effective Date, is in conflict with the laws of Your state of residence on that date is deemed amended to such laws.

Modification

Nothing contained in this policy may be changed in any way unless the change is made in writing, signed by one of Our officers and sent to You. No person, including Your agent, has any power on behalf of the Company to:

(a) make or modify this contract of insurance;

(b) extend the time for paying a premium;

(c) waive any forfeiture; or

(d) bind Us by making any promise or representation.

GEM INSURANCE COMPANY

MATERNITY EXPENSE BENEFIT

Maternity Expense Benefit

1. Benefits. If You or Your Spouse incur eligible expenses for Pregnancy, while insured under this policy, We will pay eligible charges after the deductible at the applicable percentage up to the maximum amount listed on the Policy Schedule as a result of any one (1) Pregnancy.

   Complications of Pregnancy will be treated as any other illness and will not be subject to the maximum amount listed in the Policy Schedule Complications of Pregnancy are limited to only those conditions specifically defined in the Definition Section of this policy.

2. Eligibility. To be eligible for this coverage You must.

   (a) select maternity benefits and pay the premium for this coverage;

   (b) the Pregnancy must have begun on or after the Effective Date of the coverage; and

   (c) the pregnant person must be continuously insured under this policy for not less than ten (10) months from the Effective Date of maternity coverage. If the Pregnancy is terminated early due to a miscarriage, the ten (10) month waiting period will not apply assuming that the Pregnancy began after the Effective Date of the maternity coverage

3 Eligible Expenses. Usual and Customary Charges actually made for the covered person as follows.

   (a) Mother

      (1) Hospital room and board.

      (2) Other Hospital services and supplies provided during Hospital confinement.

      (3) Services of a Physician/Practitioner for obstetrical or surgical procedures and care.

   (b) Newborn Child

      (1) Routine nursery charges made by the Hospital for well newborn Child for a maximum of three (3) days from the date of birth, except when Short-Stay Maternity benefits are paid

   (c) Termination. Maternity expense benefits end when your coverage ends.

   (d) Limitations. All exclusions, limitations, and limited benefits outlined in the Specifications Section of this policy apply to this benefit.

GEM INSURANCE COMPANY
INDIVIDUAL DENTAL CARE EXPENSE BENEFIT

If an Insured Person incurs covered eligible dental expenses rendered by a licensed dentist, the Company will pay the applicable co-insurance percentage, as outlined in the Policy Schedule, for Usual and Customary Charges which exceed the deductible, up to the Aggregate Maximum Benefit.

1. **Aggregate Maximum:** The aggregate maximum benefit payable under these provisions for all services provided to any Insured Person is the amount shown on the Policy Schedule.

2. **Deductible:** Each Insured Person must meet a separate dental deductible in the amount shown on the Policy Schedule. It applies to all eligible charges incurred during the same calendar year except for diagnostic and preventative services for which the dental deductible is waived.

3. **Alternative Treatment Plan:** In the event there are several ways to treat a particular dental problem; Our dental consultant will review the claim and We will base its payment on the less costly amount of benefit that meets acceptable dental standards for treatment. We reserve the right to pay benefits for the most economical method of dental treatment. If You and the dentist decide You want the more costly treatment, You are responsible for the charges beyond those provided for the less costly appropriate treatment.

4. **Covered Eligible Expenses - Dental Care:** Benefits for Usual and Customary fees for the following necessary dental care rendered by a licensed dentist, as determined by the standards of generally accepted dental practices:

   A. Preventative and Diagnostic Services:

      (1) Oral examinations

      (2) X-rays

      (3) Study models

      (4) Fluoride treatments for children under 16

      (5) Prophylaxis (cleaning and polishing)

      (6) Space maintainers

      (7) Sealants

   B. Basic Services:

      (1) Palliative emergency treatment

      (2) Fillings

      (3) Tooth extractions

      (4) Oral surgery

      (5) Endodontics (including pulpotomy, pulp capping, root canal treatment)

      (6) Apicoectomy

      (7) Periodontal services

   C. Major Restorative/Prosthodontic Services:

      (1) Inlays or onlays

      (2) Crowns

      (3) Bridges

      (4) Dentures (full or partial)

5. **Limitations:**

   A. Preventative and Diagnostic Services:

      (1) Oral examination fees are paid once every six (6) months.

      (2) Complete mouth and/or panorex x-rays are benefits once in a three (3) year period and are limited to Insured Persons age ten or older, unless special need is shown. Bitewing x-rays are benefits once every six (6) months.

      (3) Study models are a payable benefit only for major restorative and/or prosthodontic services that involve major reconstructive type services.

      (4) Topical fluoride is a benefit only once every six (6) months, and limited to eligible persons under age 16.

      (5) Prophylaxis is a benefit only once every six (6) months.

      (6) Space maintainers are a benefit only to maintain space of missing primary teeth for permanent tooth eruption.

      (7) Sealants are a covered benefit for permanent molars and bicuspids and are paid one (1) time for each tooth to age 16.

   B. Basic Services:

(1) Palliative emergency treatment is a payable benefit only when that is the only service provided on that day. If other charges are made at the same time, such as exams, etc., then those services will be paid in lieu of palliative emergency treatment.

(2) Fillings are a benefit on the same tooth surface once every eighteen (18) months and are limited to one (1) filling per surface.

(3) General anesthesia is a benefit only when used in conjunction with oral surgery. General anesthesia and oral surgery must be provided by different providers or this service is not covered. Hypnosis, premedication, relative analgesia, and I.V. sedation are not payable benefits.

(4) All endodontic procedures include cultures and final x-rays within the total fee. Separate charges are not a covered benefit.

(5) One pulp cap per tooth is a benefit only when the tooth shows special need. Additional allowance for base is not a covered benefit.

(6) Periodontal service allowances include all post-operative care for six (6) months following treatment.

(7) We do not provide benefits for separate charges for tooth preparation, temporary restorations, impressions or local anesthesia, as these services are components of a complete procedure for which a single charge is made.

C. Major Restorative/Prosthodontic Services:

(1) Benefits will be available after the Insured Person has been enrolled under the plan for nine (9) consecutive months.

(2) Replacement of an existing denture will only be covered if it cannot be made serviceable and is at least five (5) years old. Services which are necessary to make such an appliance serviceable will be provided in accordance with the policy.

(3) Relines are a payable benefit once every three (3) years.

(4) Tissue conditioners are provided once to prepare the tissue for final impressions for new dentures or relines.

(5) Prosthetic devices including bridges as well as other major restorative procedures are a benefit once every five (5) years.

(6) Porcelain crown, porcelain fused to metal, or gold will not be provided for patients under 16 years of age. Special consideration may be given in special need cases after review by the plan dental consultant.

6. **Exclusions:**

A. Treatment with respect to congenital or developmental malformation or surgery or dentistry primarily for cosmetic purposes, including the replacement of teeth congenitally missing.

B. Services or procedures started prior to the date patient became insured under this plan. (Includes replacement of missing teeth lost prior to the Effective Date of coverage.)

C. Experimental procedures.

D. Hospital charges or surgical facility charges in conjunction with dentistry.

E. Periodontal splinting.

F. Gnathological recordings.

G. Charges for appointments scheduled and not kept.

H. Charges for training, educating, or counseling a patient except when incidentally provided, without a separate charge, in connection with other covered services.

I. Charges for shipping, handling, postage, interest, finance charges, or completion of claims forms assessed by the dentist.

J. Charges for replacement of lost or stolen prosthetic or orthodontic devices or appliances or duplicates of such devices or appliances.

K. Charges for athletic mouthguards.

L. Charges for dental implants and associated crowns and bridges.

M. Charges in connection with temporomandibular

joint dysfunction (TMJ); upper or lower jaw augmentation or reduction procedures (orthognathic surgery), or appliances or restorations necessary to increase vertical dimension or restore occlusion, including but not limited to:

(1) Restorative treatment

(2) Prosthodontic treatment

(3) Full mouth rehabilitation

(4) Bone resection

(5) Injection of joints

(6) Splints

(7) Physical therapy

N. Habit control appliances, such as finger sucking appliances or night guards.

O. Orthodontic services, supplies, and treatment.

P. Prescriptions.

7. **Proof of Loss:** Whenever You or Your dependents are entitled to any of the benefits provided in this policy, immediately obtain a claim form from Us.

8. **Pre-Estimate:** For expenses which will exceed $200, a pre-estimate must be completed before treatment begins. Have your licensed dentist complete the dentist section of the claim form. Submit the form to Us with Our request for a benefit determination.

9. **Follow These Steps for Prompt Claim Settlement:**

   A. Fill out the insured's section of the claim form for Your claims or for Your dependent's claims and sign.

   B. Portions of form labeled dentist's statement must be filled in and signed by the dentist.

   C. Secure itemized bills from dentist.

   D. Return the completed and signed claim form to Us for processing.